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A PLEA FOR THE DEVELOPMENT OF PATHOLOGY *

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Pathology, in its early development, was a by-product of anatomy during that period when the first dissections of the human body were developing anatomic knowledge. Morgagni, Vesalius, Fallopius, Eustachius, and others of the earlier anatomists, whose names are still attached to hydatids, tubes and various other structures of the body, made note of abnormalities encountered in the course of their anatomic investigations. Pathology, during this early stage of its development, could not be considered a subdivision of knowledge with standing of its own. It noted objectively gross anatomic deviations from the normal, but, because of the fantastic humoral doctrines of disease then prevailing, it could not intelligently concern itself with the processes that had led to the abnormalities.

It was not until Virchow showed that the cell doctrine applies to abnormal tissues as well as to normal ones that pathology began to establish itself as the most fundamental of the medical sciences. With the knowledge that the constituents and products of abnormal tissues are derived from preexisting normal structures, it became possible to establish the fact that abnormality is not some new and distinct state of the body, for the explanation of whose causation it was necessary to suppose mechanisms foreign to those usually at work. It became possible to show that pathologic lesions result from mechanisms of which the body normally makes use, and we began to arrive at an understanding of processes as opposed to anatomic end-results. It was quite a distinct advance in our conception of disease to know, for instance, that the pus corpuscle is a derivative of the normal leukocyte, axiomatic as such knowledge may seem to us today. But it was an even greater advance to learn that the mechanisms which lead to pus formation are physiologic ones which the body employs under normal conditions.

PRESENT STATE OF PATHOLOGY

With the applicability of the cell doctrine to abnormal tissues established, pathology entered on the era which has added to medical literature a long list of most illustrious names. The leaven added by Virchow and his successors is still at work, but it is fair to ask whether America has contributed and is contributing its proper share to the advancement of pathology. If we have not done and are not doing our share, then it behooves us to inquire into causes and to attempt to overcome the retarding forces that may be operative. Our first question we shall have to answer in the negative; we shall have to admit that this country has not contributed as much as it ought to the literature of pathologic anatomy and histology, and that, with only one or two exceptions, it has not developed any outstanding philosophers in the field of pathology. Unfortunate as this is from the standpoint of the development of pathology, it reflects itself even more seriously in the attitude of the large body of the medical profession, the clinicians and practitioners, toward pathology. It reflects itself also in the medical education of the country; the medical student is all too apt to look on pathology as one of the "theoretical" subjects of the first half of the curriculum, subjects which are to be forgotten as rapidly and as completely as possible during the final two years of "practical" work.

FACTORS THAT HINDER DEVELOPMENT

The factors that underlie the present state of pathology in this country are probably national, rather than local, in character. First and foremost in importance is the unsympathetic and even antagonistic attitude toward postmortem examination, an attitude manifested not only by a large part of the lay public but also, unfortunately, by a part of the medical profession. Medicine, in this country, has not yet achieved for itself such a position that every possible aid is given it as a science whose chief aim is the betterment of the condition of mankind. Too many pathies and cults share with scientific medicine the affections of the laity, for medicine to demand as a right certain privileges which it should have. The result is that the layman, even if he is of more than average intelligence, does not understand the importance of the necropsy to medicine, nor has he any appreciation of the effect which knowledge gained at the postmortem table may have on some ill to which he may later fall victim. A change in conditions, which would result in the performance of necropsies in a minimum of from 75 to 80 per cent. of all patients dying in hospitals, would evidence itself in a short time by an incalculable development of pathology, of medical teaching, and of medical practice.

We can hope for no improvement through laws which make postmortem examination compulsory; hence it is necessary to determine, if possible, some of the causes underlying the present hostile attitude. If we can know causes, we may be able to overcome them to a greater or less degree by other than legal means, education being the chief one. It must be remembered, however, that not only the laity, but also a part of the medical profession, needs education. Almost every

* President's address, read before the Chicago Pathological Society, Oct. 9, 1922.

* From the Nelson Morris Memorial Institute for Medical Research of the Michael Reese Hospital.

hospital staff has a few members who not only make no effort to obtain consent for postmortem examination of their cases, but who may even actually frown on any exertion to this end put forth by the pathologist, the intern or the administration of the hospital.

Factors other than ignorance and indifference have probably received a larger share of blame than they deserve. Religious objection is frequently mentioned as an insuperable obstacle to obtaining consent for necropsies, especially in those hospitals a large proportion of whose patients are Catholics or Jews. The essential factors in such hospitals, as in all others, are ignorance and indifference, rather than religious belief. My first experience was in a Catholic hospital whose governing Sister Superior was so broad minded and intelligent that she herself frequently accepted the responsibility of ordering a necropsy, knowing that she could overcome objections based on religion alone; the result was a high percentage of necropsies in a hospital which previously had had very few. At the Mount Sinai Hospital of New York the necropsy percentage has been increased, by well directed effort, from a negligible figure to more than 50 per cent., and at the Michael Reese Hospital of this city the latter figure is also being approached during the present year. Such experiences indicate that religion is not an insurmountable barrier to the development of a worth-while postmortem service. The attitude of the hospital staff and of the hospital administration is a much more important factor than religion or other factors that might be mentioned.

While objection to postmortem examination is a general condition, the percentage of permission necropsies varies in different hospitals, communities and localities, indicating that lack of effort is perhaps as much to blame as lack of knowledge. How unsatisfactory conditions are in Chicago is indicated by the figures published by the Institute of Medicine of Chicago. In 1920, in a total of thirty-nine hospitals, not including Cook County Hospital, whose percentage was 12.7, there were 4,868 deaths, in only 12 per cent. of which permission necropsies were made. In six of the hospitals, the percentage was 20 or over, ranging from 20.1 per cent. to 52.2 per cent. for this group; in seven it was from 10 to 20 per cent.; in ten, from 5 to 10 per cent., and in nine, from 1 to 5 per cent. These figures are not of such a magnitude as to induce an egotistic overdevelopment of local pride; the highest percentage attained by all of the hospitals, 52 per cent., should be the minimal aim. The opposition of the Chicago Association of Undertakers is a local factor of importance. While this organization, through its governing board, has taken a stand that will not permit a hearing of intelligent arguments, many of the members of the association, as individuals, are amenable to reason and can be quite helpful. So far as the local situation is concerned, I am inclined to agree with the statements of the committee of the Institute of Medicine, that "while prejudice and ignorance, together with religious scruples, account for much of the difficulty encountered in obtaining permission for necropsies, the alleged prejudice against necropsies is not so great as has been assumed," and that "indifference in the matter of necropsies often goes hand in hand with professional indifference as to correctness of diagnosis and treatment."

It might be argued that, although there is a paucity of necropsies in this country, surgical material should be ample for the development of pathology. Of such material there is certainly no dearth, and much of it is of value. It is difficult to understand how the surgeon, through whose hands passes a wealth of material in a condition ideal for study, can do otherwise than become a competent pathologist; mere contact with the material, aided by good eyesight, should do the work. As a matter of fact, however, one of the striking features of surgery in this country is the rarity of the surgeon who knows pathology. For most surgeons the chief point of interest in abnormal tissues is the technic of their removal, rather than the condition which the tissues may show or the processes that have been active. The attitude of the surgeon toward the tissues that he removes is only part of our general reaction of indifference to the development of pathology; and until we acquire a deeper interest in general pathology in this country, we cannot hope that the surgeon or other specialist will become adequately trained in this science. While, therefore, surgical material should offer a fruitful field for study, it will not be fully utilized until a change in the lay and professional attitude toward postmortem examination shall have brought about a broader knowledge of pathology on the part of the profession as a whole.

Still another general factor that retards the development of pathology is the absence of an American journal devoted primarily to pathologic anatomy and histology. We have nothing in this country comparable to *Virchows Archiv*, Ziegler's *Beiträge*, or the *Frankfurter Zeitschrift für Pathologie*, journals whose influence on modern pathology, even today, cannot be measured. Because there is no similar publication in this country, the pathologist hesitates to submit a paper on a purely pathologic subject to any of the existing journals. Since he knows that he will have this hesitation in connection with the completed work, he hesitates to begin the work at all. The result is an inadequate presentation of even such material as does become available. There is no doubt that such a journal would be a great stimulus to the publication of valuable work; no other one thing would be so immediately effective.

EXPERIMENTAL RESEARCH

Our existing journals reflect the tremendous development which experimental medicine in all its branches has made in this country. This development, due in part, at least, to the stagnation of pathology caused by lack of material, has, in its turn, led to further retardation of pathology. For many, experimental work on animals, in the absence of human pathologic material, becomes a path of least resistance. The spectacular results occasionally obtained in experimental work have also helped to enhance the importance of such work. The increasing number of full-time clinical teaching positions has directed the energies of a large number of investigators into experimental work of clinical application. As a result of these and other factors, experimental research in the United States has reached a development of which we may well be proud. But without laying oneself open to the charge of belittling experimental research, one may be permitted to express a fear of certain tendencies that are manifesting themselves. Of these, one is the greater emphasis sometimes placed on "experimental" than on "work"; merely because a piece of work is experimental in character, it may receive a greater measure of credit than the work itself actually deserves. The great desire to do something experimental, because experimental

research now occupies the center of the stage, may lead to the carrying on of work whose inception was not preceded by proper conception, by the thought and planning and imagination that every problem should receive before the actual attack on it is begun. And in the interpretation of results there is sometimes apparent a lack of calm contemplation and of knowledge of underlying principles which is characteristic of mediocrity. Imagination and speculation have no place in the reading of the actual results of experimental procedures, but they should have a part, when properly controlled by sound judgment, in the planning of work and in the discussion of its applications. The philosophic type of mind is not being developed to the degree that one might wish. This may be due, in part, to the fact that much of our experimental research is being done by younger investigators, who have not reached the age of contemplation and reflection, and who work more from without than from within. While mental youth, so valuable because of the enthusiasm and energy which it applies to work, may be an element in our present tendencies, one may express the fear that the latter are not such as will lead to the development of philosophers, even under the mellowing effect of advancing years.

Experimental research needs a period of reflection and introspection, in order that it may properly correlate its findings. It needs occasionally to measure its results in terms of pathology in order to be sure that it is not going astray. The development of the experimental sciences, instead of retarding pathology, should lead to a fuller flowering of the latter. Pathology, for its further advancement and interpretation, needs to have applied to it the results which have been obtained by the application of experimental methods to all the other sciences. Virchow and his successors carried us to the border of the cell; it remains for the newer research to admit us into the cell itself. The cellular pathology of Virchow must become the intracellular pathology of the future. But while we are waiting for the full development of the latter, it is necessary to keep alive an interest in pathology as we already know it; we can build for the future only on the knowledge of the past. Biologists with a wide knowledge of cytology, chemistry or physics will find in pathology, not a dead subject that is to be disregarded, discarded and forgotten, but a most interesting field for study if they will but remember that end-results are not so important as processes in pathology. I would, therefore, plead that our future development be not entirely at the expense of pathology, and that in the evaluation of work done, that of the pathologist be not entirely discredited. Pathology must still continue to be the foundation of clinical medicine; medical practice can be no better than its basic element. And pathology must be the final measure for determining the value of our experimental work and its applicability to the problems of human medicine.

INFLUENCE OF LOCAL SOCIETIES

While some of the factors that hinder the development of pathology are general in character, rather than local, and are not to be overcome by the endeavors of any local group of individuals, it has seemed to me that our local societies can perform a most useful function in maintaining an interest in pathology. This is my reason for making this plea for the development of pathology before this society. It should be our aim to enlist the interest of the clinician as well as of him who is concerned primarily with pathology and its related subjects. The clinician should be stimulated to learn pathology, not merely by listening, but by presenting his own interesting material. The younger workers who are engaged in the laboratory, either permanently as a life work or temporarily previous to going out into practice, should be urged to present the products of their labors from time to time, in order that the results of their experimental and other work may have the widest possible application. For keeping the lamp alight, a local society such as this is the most important agency.

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EXERCISE TOLERANCE IN HEART DISEASE *

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Exercise tolerance, a term generally used the last few years in connection with heart disease, expresses a new idea which has done much to illuminate an obscure section of cardiac diagnosis and prognosis. The implications of this idea are far-reaching and not yet fully appreciated. It puts before us the conception that we can best judge of the heart's capacity or reserve power by observing the way exercise is tolerated rather than by various other procedures. The capacity for physical exercise is undoubtedly a valid criterion of the condition of the heart's efficiency, because the capacity for exercise depends essentially on the heart's ability to increase its output, provided the lungs, the nervous system and the skeletal muscles are functioning in a normal manner. This is a most important statement, the truth of which is not generally recognized. An essential function of the heart is to furnish an adequate supply of blood to the working muscles. The blood flow through the muscles during heavy work may be increased as much as eight times that existing during rest. This is only accomplished through harder work by the heart, whereby its great reserve power is utilized. What could be more logical than to base our judgment of the heart's capability on the result of a procedure which calls into action that reserve power about which we are seeking information?

If we admit the validity of the exercise tolerance test, we are at once confronted by the problem of deciding just how to be certain that a given exercise is tolerated or endured. By tolerated, we mean that it is performed without overtaxing the heart. To quote Bainbridge,[1] "The essential feature of overtaxing the heart (overstress) is clearly lessened contractile power of the heart. The less its contractile power, the more must the heart dilate in order to obtain the energy necessary to maintain its output. If the power of the heart sinks to a level at which it can barely maintain the output necessary during rest, the heart will remain fully dilated, long after exercise, and under the steady pressure of the heart on the pericardium, the latter will give way . . . . With increasing dilatation and steadily declining efficiency, a point will be reached at which it can no longer transform into work sufficient energy to increase its output or even to maintain a

* From the cardiac clinic of the New York Hospital.
* Read before the New York Academy of Medicine, Oct. 19, 1922.
1. Bainbridge, J. A.: Physiology of Muscular Exercise, New York, Longmans, Green & Co., 1919, pp. 82-200.

normal output. When this stage is reached, failure of the circulation is at hand."

There are a number of subjective symptoms—dyspnea, palpitation, fatigue and precordial distress—which are of much help in deciding the question of overtaxing; also a number of symptoms and physical signs which may be observed—dyspnea, the expression and color of the face and the return of the pulse rate to normal inside of a few minutes. In instances in which these symptoms are marked, we are certain that the exercise has *not* been tolerated. Often, however, these various symptoms are not marked, and we are in much doubt as to whether the exercise has been tolerated. In these patients, I have found the plotting of the systolic blood pressure curve of much value. A "delayed rise" and "prolonged fall" indicate, we believe, that the exercise has not been well tolerated. In other words, the heart's capacity has been overtaxed.

The question naturally arises as to the type of exercise we shall use in determining exercise tolerance. It is difficult, even impossible, to reduce various forms of exercise to a common denominator. Therefore, the form, amount and time consumed should always be specified when the exercise tolerance of an individual is stated. The necessity for normal standards is apparent if we expect to detect moderate decreases in the heart's capacity. We are able, however, to appreciate any considerable deviation from the normal, and the patient himself generally knows whether his capability for physical activity has undergone any marked diminution. Dr. May Wilson [2] has performed a most valuable service by determining normal standards of exercise tolerance for children. Similar work remains to be done for adults. In determining the amount and kind of exercise to be used as a therapeutic measure, or the exercise permissible for a person with heart disease, however, we are not hampered by the lack of normal standards: we simply decide whether they can tolerate any given exercise.

It may be of interest to discuss briefly the value of determining the condition of the heart's reserve power in various normal and diseased states by means of exercise tolerance tests. In persons recovering from protracted infectious diseases, the time to permit any physical activity and the amount of increase advisable from day to day can be intelligently determined only by an exercise tolerance test. As a practical example, a patient who has been confined to bed for some time is able to sit on a chair and walk a few steps as soon as he can flex each thigh alternately on the abdomen ten times without overtaxing the heart.

We often see persons in whom heart disease has been diagnosed who show nothing abnormal except a systolic murmur over the heart. If they tolerate vigorous exercise, it does much to dissipate the apprehension they may feel about taking exercise and strengthens the physician's conviction that he is dealing with a normal heart. This, perhaps, will make unnecessary the advice so often and so solemnly given these patients to be cautious about physical activity.

Persons with valvular disease show the greatest variation in their exercise tolerance whatever the exercise may be, swinging dumb-bells, climbing stairs, walking, etc. At one extreme, there is minimal tolerance, which may be stated in terms of different exercises thus: ability to (1) walk on the level a distance of 300 feet, in two minutes; (2) swing the body trunk from a stooping position, the arms hanging between the legs, to an upright position ten times, in twenty seconds; (3) climb a flight of stairs with a 10-foot rise, in twenty seconds. At the other extreme, patients may show a tolerance equal to a normal person: ability to (1) swing a 20-pound dumb-bell fifty times, or (2) climb a flight of stairs with a rise of 60 feet, in thirty seconds. Only by determining their exercise tolerance can we prescribe intelligently the amount of physical activity most suitable for them.

There are certain patients with advanced mitral stenosis who have a very small exercise tolerance. These patients have to be extremely careful about their physical activities. They improve but slightly, or not at all, on graduated exercise, and they have to take digitalis almost continuously. It is interesting to see how long a time they are fairly comfortable with their very limited exercise tolerance. I have watched several such patients for nearly three years. Patients with aortic valve disease stand physical activity, as a rule, better than those with mitral stenosis. When they show a persistently low exercise tolerance, the duration of life is generally short.

I believe that as time goes on the validity of the exercise tolerance test for determining the condition of the heart's functional capacity will become generally recognized, and our knowledge of heart disease will be much enriched through the facts acquired by this comparatively new method of cardiac diagnosis.

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2. Wilson, May G.: Exercise Tolerance of Children with Heart Disease as Determined by Standardized Test Exercises, J. A. M. A. **70**: 1629 (June 11) 1921.

OCULAR MANIFESTATIONS OF THE RAT WHICH RESULT FROM DEFICIENCY OF VITAMIN A IN THE DIET *

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Various names have been given to certain ophthalmologic phenomena which accompany nutritive disturbances in experimental animals. Long before the vitamin hypothesis was formulated, Falta and Noeggerath [1] described a conjunctivitis with crust formation beginning about the fourth week and lasting until death, in rats fed on a diet which, from their description, must have been free from vitamin A. Knapp,[2] continuing the studies, described the eye symptoms as beginning with photophobia, followed by a slimy secretion in the corners of the lids so that it was found difficult to separate them. This was followed by turbidity of the cornea and ulceration. Osborne and Mendel,[3] in 1913, described the ocular phenomenon as an "eye disease," which, as they showed later,[4] cleared up by adding butter fat or cod liver oil to the diet. McCollum and Davis [5] also called attention to the condition of "inflamed eyes," which McCollum later designated xerophthalmia. He and his associates [6] noticed that there was edema of the eyelids with hemorrhage

* This investigation was made in cooperation with Drs. Thomas B. Osborne and Lafayette B. Mendel, under whose direction the feeding of the experimental animals was conducted.

1. Falta, W., and Noeggerath, C. T.: Beitr. z. chem. Phys. u. Path. **7**: 313, 1906.
2. Knapp, P.: Ztschr. f. exper. Path. u. Therap. **5**: 147, 1908.
3. Osborne, T. B., and Mendel, L. B.: J. Biol. Chem. **16**: 423, 1913.
4. Osborne, T. B., and Mendel, L. B.: J. Biol. Chem. **17**: 401, 1914.
5. McCollum, E. V., and Davis, M.: J. Biol. Chem. **21**: 180, 1915.
6. McCollum, E. V.; Simmonds, Nina, and Parsons, H. T.: J. Biol. Chem. **33**: 411 (March) 1918.

of the conjunctiva. The eyes became swollen so badly that they were opened with difficulty. The cornea became inflamed, and unless the missing dietary essential was given, blindness speedily resulted. Freise, Goldschmidt and Frank [7] showed that there was a loss of hair from the eyelids, followed by a retraction of the eyeball. Corneal lesions were noted, and particularly a corneal dryness which was quickly followed by cloudiness and ulceration without much inflammation. Other investigators have not added much to the ophthalmic picture.

Most observers have found that the ocular manifestation is not a mere chance one, but is due to a definite lack of vitamin A in the diet. The different names given to the abnormal eye condition are derived from the nomenclature of the eye diseases of man. It is therefore important that a comparison between the lesions found in the rat and xerophthalmia, keratomalacia and general ophthalmia found in man be definitely made; hence the present study of the progressive visible changes in the eye and its adnexa from an ophthalmologic standpoint.

In order to examine in detail the progressive ocular changes which have been described very vaguely by other observers, five groups of experimental animals have been secured. The first consisted of six rats fed on a mixed diet. The second group, consisting of six animals fed on a food mixture devoid of vitamin A, was killed when they showed an excessive lacrimation and beginning photophobia with a very slight suggestion of sanguineous tinging of the secretion. The third group of seven animals, fed on the same diet as the second, was allowed to progress to the stage at which plaques fatty in appearance accumulated in the fornices, and the cornea showed signs of dryness and loss of corneal reflex. The fourth group of animals was continued to a stage at which the cornea showed signs of breaking down when the rats reached a condition of extreme nutritional decline. In this group are also included animals fed on the same diet which, further, was also made poor in vitamin B. Of the last group (eight animals), some subsequently received cod liver oil and butter fat and others orange juice—all of which contain vitamin A—as supplements to the diet in order to secure recovery.

All animals except two were killed by chloroform anesthesia, and were examined immediately. The eye, the upper and lower lids, the lacrimal gland and the orbital fat were dissected out carefully and fixed in Zenker's fluid.

In order to determine whether the method of death by chloroform might have any effect on the microscopic finding of the eye and its adnexa, a further group of six animals consisting of two cured and four normal rats was killed by the injection of 2 per cent. mercuric cyanid subcutaneously into the abdominal region. The tissues were fixed as in the previous cases. Opportunity was also secured to examine many instances of eye disease among the rats living on abnormal diets in the laboratory of Drs. Osborne and Mendel.

The first sign of an ocular complication is that the eyes water very freely, and the animals seem to dread the light more than a normal individual does. The normally prominent protruding eye of the rat gradually recedes into its bony orbital socket, and the photophobia increases. The animal facies assumes a sleepy appearance. Lacrimation increases and, instead of being watery, becomes more viscid. It is at this stage that the animal shows some signs of ocular irritation and rubs the lids with its front paws. A slight edema of the eyelids becomes manifest, and the viscid lacrimal secretion assumes a sort of serosanguineous character accumulating in the inner canthi in the form of crusts. The hair of the lids falls out, and the latter become thicker. When the swollen lids, which at this stage may be matted together with a dry secretion, are pushed back, accumulations of semisolid, fatlike, yellowish-white patches of secretion or perhaps exfoliated epithelium in the upper and lower fornices often appear.

In the early stages, the cornea shows no visible changes except for the marked congestion about its junction with the palpebral conjunctiva. There is no visible sclera in the albino eye. With the progress of the eye disturbance and following the swelling of the lids, the cornea shows some signs of haziness, particularly about the periphery. As the patches increase, the normal cornea reflex disappears. Frequently they are seen on the center of the cornea, but more often extend on to the corneal surface from the fornices. Thereupon the cornea becomes dry, lusterless and oily in appearance, losing its normal transparency.

In our earlier observations, it was thought that the central, fatlike plaques were ulcers; but as our work progressed, it was found that they could be easily removed from the cornea. In order to see how much destruction of the cornea is produced when the plaques are removed, the tissue was stained with fluorescein; to our surprise, it rolled over this area as water does over an oily surface. Seen through a corneal loupe, the tissue seemed to be intact; but a slight swelling in the form of a bleb occupied the areas from which plaques had been previously removed. At such times the animal showed marked debility owing to its nutritional decline. Furthermore, if the experiment was continued, the corneal tissue showed frank ulceration, which stained with fluorescein; and, finally, panophthalmitis set in with complete destruction of the eye.

The iris observed in the early stages of the experiment showed very little change; but when the congestion of the conjunctiva was marked, the folds of the iris, observed with a Berger loupe, also became prominent through congestion. Because of the nutritive decline of the animal and the haziness of the cornea at such stages, further accurate observations on the iris became almost impossible.

From the standpoint of a comparison of these ocular manifestations found in the albino rat with the somewhat similar clinical condition sometimes found in man, the early lesion resembles that described in the ophthalmic literature as xerosis of the conjunctiva and cornea; and the progressive changes of the cornea in the rat are like the condition known as human keratomalacia.

In previous communications,[8] we stated that the eye changes resulting from deficiency in vitamin A, and characterized by a widespread keratitis in the advanced stage, do not begin in the cornea but have their origin in the lids; and from the review of our material it appeared that there is either a marked degenerative or an inflammatory change in the lacrimal gland. These alterations may account for some of the phenomena of so-called xerophthalmia.

7. Freise, E.; Goldschmidt, M., and Frank, H.: Monatschr. f. Kinderh. **13**: 424, 1915. Goldschmidt, M.: Arch. f. Ophth. **90**: 354, 1915.

8. Yudkin, A. M., and Lambert, R. A.: Proc. Soc. Exper. Biol. & Med. **19**: 375, 376, 1922.

In a later paper I shall discuss the gross and microscopic pathology of the rat eye and its adnexa, and the resemblance of its phenomena to those found in pathologic conditions of the human eye; also the different views of the etiology of these ocular manifestations.

CONCLUSION

It is my impression that, from a clinical standpoint, the incipient changes in the eyes of rats showing nutritive disturbances on diets deficient in vitamin A are like the condition known as xerosis of the conjunctiva and cornea in man; and the more advanced picture is that of keratomalacia.

THE VALUE OF REST IN CASES OF EMPYEMA AND LUNG ABSCESS

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In acute pulmonary tuberculosis and in certain derangements of the nervous system, it is generally admitted that the rest regimen is a success. This treatment requires complete relaxation, both mental and physical, and any influence which causes increase in the cardiac effort constitutes exercise and is the antithesis of rest. In order to secure the maximum amount of rest, something more than being confined to bed is required. Apprehension, worry and mental depression act as physical stimulants, while emotions caused by noise, anger and arguments upset the vasomotor equilibrium and defeat efforts employed to obtain this form of treatment. The patient should therefore be freed from all responsibility, quietness assured, and a pleasant, cheerful and optimistic environment established.

When dealing with a severe infection, such as the acute stage of empyema, rest is imperative. Following the active phase, the inflammatory process in the pleura becomes localized, a pyogenic membrane forms, and a different condition presents itself for treatment. In this state a mechanical problem may exist, owing to a displacement of the mediastinum or limitation of lung capacity with associated dyspnea and circulatory disturbances. By this time the patient has become exhausted, and little difficulty is experienced in convincing him of the importance of rest. It should be definitely established that the pleural sac contains pus; this is usually determined by the introduction of a needle, the variations of the leukocyte count, the history and the physical examination, including roentgen-ray findings. If an empyema exists, thoracotomy should be performed. Prior to this, rest has been the natural result of exhaustion. Following surgical interference, its use as a therapeutic measure is unfortunately rapidly discarded, because the patient is improving, the offending substance in the chest has been removed, and a slow but definite return to a feeling of well-being is experienced. It is now that the continuation of absolute rest is of such great importance and often so difficult to secure.

Guarded and graduated exercise may be added to the treatment. Sitting up in a chair and taking a few steps each day constitute the best means of slowly winning the patient back to a state of confidence. The change should be gradual, for too vigorous mental or physical exercise frequently results in an exacerbation of the affection.

METHOD OF TREATMENT IN EMPYEMA

During the last three years, twelve cases of empyema have been treated at our clinic in the following manner:

Before thoracotomy was performed, there was reason to believe that the acute inflammatory process in the pleural cavity had subsided and that the empyema was well walled off. Drainage was established at the lowest point (posterior axillary region). In each case, before thoracotomy, an attempt was made to ascertain the position of the diaphragm by fluoroscopic and roentgenographic study. Adequate drainage being of greatest importance, the surgical communication between the pleural cavity and the exterior was made in such a manner as to insure an orifice equal in width to that of the lower empyemic area. A large, short rubber tube was then inserted, and some form of one way valve was attached to the exposed end of the tube.

For the first ten days after rib resection, the typhoid rest regimen was instituted. This was followed by a ten day period in which the patients were allowed to sit up for a while each day and the use of the commode was permitted. No further privileges were granted, and in the majority of cases this treatment was continued until the discharge had disappeared for at least two weeks.

A daily charting of the temperature and a frequent leukocyte count during the period of convalescence revealed, in some instances, evidence of drainage interference. Single roentgen-ray films usually revealed a displacement of the drainage tube, the correction of which brought about a subsidence or disappearance of untoward symptoms.

Fresh air proved to be an excellent adjunct to the rest treatment, and when possible the patients were placed on porches, some of them spending the entire twenty-four hours outdoors. This improved the appetite and exerted a markedly beneficial effect on the nervous and mental state. The patients were encouraged to eat a liberal amount of nutritious food; those underweight were given special attention with reference to diet, and the bowels were regulated by a liberal supply of liquid petrolatum, fresh vegetables and the consistent drinking of a reasonable amount of water.

An average case required from four to eight weeks in bed under this regimen; the severe cases required a longer time.

When chronic empyemic cavities persisted after a reasonable period of rest, thoracoplastic surgery was employed. The patients stood surgical interference well, the long standing absorption having apparently established a definite immunity to the infecting organisms.

Of the twelve cases treated in this manner, seven were acute and resulted in satisfactory recoveries. The average stay in bed following thoracotomy was thirty-two days. Of the remaining five chronic cases, resection was performed in the first about three months before the patient came under our observation, but after sixty-four days of bed rest all symptoms disappeared. The second patient came for treatment a year after resection; after the establishing of a more complete drainage, about 1,600 c.c. of pus was released. This patient gained 40 pounds (18 kg.) in weight during three months of rest treatment, but the immense empyemic cavity did not recede, and a four stage thoracoplastic operation, necessitating the removal of parts of the lower eleven ribs, was followed by a complete recovery. The third patient, a boy, aged 9, suc-

cumbed to a meningitis following the thoracotomy for the relief of an empyema of three months' standing. The fourth patient made an excellent improvement, but refused surgical treatment for the relief of a persistent small sinus. The fifth case is reported in detail:

History.—A man, aged 27, came under my observation in May, 1920, twelve weeks after an attack of pneumonia followed by empyema. The previous history was unimportant. The present weight was 126 pounds (57 kg.); the average, 145 pounds (66 kg.); the maximum, 182 pounds (82.5 kg.). The pulse was 96; temperature, 99.8 F. The patient complained of weakness, depression, loose, productive cough, copious yellow expectoration frequently tinged with blood, irregular night sweats, loss of appetite, and a heavy feeling in the right side.

Examination.—The patient looked ill; his nutrition was poor, his development, fair. The shape of the chest was normal. The right thorax was deficient in expansion; a discharging sinus was present at the site of the previous thoracotomy—the seventh rib in the posterior axillary line. Feeble breath sounds and decreased resonance were elicited below the sixth rib in the back of the right thorax. Stereoroentgenograms of the chest revealed the thoracic circulatory system normal in size, shape and position. In the right lung a cloudy density occupied the root zone, and extended outward and downward to the periphery in the midaxillary region. The lung was compressed from the fourth to the eighth rib, in the anterior axillary line, and a distinct pleural space about 6 cm. in width was revealed between the lung margin and the ribs. Part of the seventh rib, posterior axillary, had been removed (original thoracotomy). The left was apparently normal.

Laboratory Examinations.—The blood Wassermann reaction was negative. Complement fixation for tubercle bacilli was negative. The white blood count was 11,000. The urine was normal. Twenty-two sputum examinations revealed no acid-fast bacilli or elastic tissue. Guinea-pig inoculation was negative.

Treatment.—Thoracotomy was performed in the posterior axillary line (ninth rib), a wide opening made in the midaxillary line (lowest point of the cavity), a drainage tube was inserted, and a small amount of Beck's paste was injected. This was coughed up in the expectoration the next day, proving the existence of a bronchial fistula. The patient was placed on bed rest for three months, during which time the discharge disappeared. The wound was allowed to close. The patient gained 34 pounds (15 kg.) and lost all symptoms except a slight cough with scanty expectoration. He was then allowed some light exercise, and a month later had a moderate hemoptysis. The rest treatment was reestablished, and at the end of two months all symptoms had disappeared.

Subsequent History.—At present, October, 1922, the patient is working. He weighs 160 pounds (72.5 kg.), feels well, and has been free from symptoms for more than a year. The empyemic cavity has healed; the bronchial fistula is apparently obliterated.

PULMONARY ABSCESS

In cases of pulmonary abscess it was found necessary to continue the bed rest for a much longer period of time than that required of the patients suffering from empyema. In most instances, the same strenuous regimen of rest was instituted as that employed in cases of active pulmonary tuberculosis. Little is thought of keeping the latter patients in bed for six months or a year. Why not enforce the same methods in the instance of a pulmonary condition that exhibits less tendency toward fibrosis?

In a period corresponding to that in which the empyemic cases were observed, twenty-one patients were found to be suffering from pulmonary abscess. Ten of these cases were acute or subacute, seven of which followed a tonsillectomy under general anesthesia, the patients coming to the clinic within a period of from four to nine weeks following the first lower respiratory symptoms. Two cases followed pneumonia, and in the tenth case a causative factor was not determined.

Of the remaining eleven chronic cases, three followed tonsillectomy under a general anesthetic, four were a sequence of pneumonia, two occurred in diabetic patients and were finally proved to be tuberculous, one case followed an extensive abdominal operation, and the last one was associated with an advanced arthritis deformans.

Of the ten patients with acute abscess, five were placed on the rest regimen and four made complete recoveries in an average of from two and a half to four months of bed rest; the fifth showed excellent improvement after two months of rest, and then left the institution.

In the eleven chronic cases, it was apparent that good results would require a longer period of rest. Three of the eleven patients recovered after being placed on this treatment for from four to seven months. In the first case the abscess had existed for two years; in the second, eighteen months had elapsed since the beginning of symptoms, while the third patient had suffered for six months prior to treatment. Of the remaining eight patients, one made a reasonable recovery except that at intervals of a few months she expectorates a slight amount of blood-streaked sputum; a second patient died following a surgical attempt at drainage; the third case terminated by a cerebral embolism; the fourth case, associated with advanced arthritis deformans, naturally gave a hopeless prognosis. The two tuberculous cases were complicated by a long standing diabetes, and the one of unknown origin showed no improvement. The following description illustrates the first case of chronic abscess mentioned in this paragraph:

History.—Mrs. C., aged 29, complained of cough of two years' duration following influenzal pneumonia in January, 1919; this was accompanied by a feeling of fatigue and anorexia. Pneumonia at the right base two years before admission was followed in three weeks by a relapse of fever, and the sudden appearance of a copious amount of offensive yellow sputum. The fever, ranging from 99.8 to 101 F., continued for about nine weeks, during which period the patient lost weight and strength. The subsidence and disappearance of the acute symptoms was in turn followed by the present chronic symptoms of cough and yellow expectoration.

Examination.—The patient weighed 110 pounds (50 kg.) gross, average 130 pounds (60 kg.), the maximum being 145 pounds (66 kg.). There was moderate dyspnea; no cyanosis; the patient was pale and weak; cough was loose, persistent, frequent, and always productive of a characteristic yellow sputum. The fingers were definitely clubbed. Nutrition had remained good, in view of the two years of indisposition. The shape of the chest was normal; there was limited movement of the right base; there were decreased resonance and medium sized râles over the back of the right lung below the fifth rib, with some prolonged expiration below the sixth and eighth ribs, in the posterior axillary line. Grouped râles were heard between the third and sixth ribs, in the midclavicular line over the right side. The patient was able to drain sputum into the main bronchi by lying on the left side. Fluoroscopy disclosed an irregular, dense shadow in the lower right lung suggestive of that seen in cases of lung abscess. Movement of the right diaphragm was definitely restricted. Stereoroentgenograms of the right lung revealed the diaphragm flattened and elevated. Within the lung substance opposite the area between the second and fifth ribs in front there was a round, dense shadow with a clearer center, rather characteristic of a pulmonary abscess. The blood Wassermann reaction was negative. Frequent sputum exami-

nations revealed no acid-fast bacilli or elastic tissue. Each specimen contained much pus.

Treatment.—The patient was placed on the rest regimen for a period of more than five months, followed by six months of graduated exercise. During this time her cough and expectoration gradually decreased; at the end of a year she was walking from 3 to 4 miles a day, was attending to her domestic duties, had gained 39 pounds (18 kg.), and was entirely free from symptoms. Nine months have elapsed since then, and the patient has remained well. Some weakened breath sounds are still in evidence over the right base, and the percussion note is not clear, owing to a thickened pleura; but the stereoroentgenograms reveal little or no signs of the frank pathologic condition of twenty months ago.

COMMENT

It is worthy of note that in the foregoing series of twenty-one cases of lung abscess, ten followed a tonsillectomy in which a general anesthetic was used. The value of other methods of treatment is highly appreciated, such as surgery, pneumothorax, irrigation, heliotherapy, postural drainage and the administration of vaccines. It is believed, however, that with the addition of a longer period of bed rest to any or all of these forms of treatment, more gratifying results would be obtained in cases of pulmonary abscess.

A SEASONAL TIDE OF BLOOD PHOSPHATE IN INFANTS

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An investigation [1] undertaken somewhat more than a year ago showed that in infants the inorganic phosphate of the blood could be raised to the normal level by means of frequent exposures to the sun's rays. It was shown later [2] that the same result can be accomplished by irradiation with the carbon arc lamp. It seemed probable that this striking phenomenon—chemical equilibrium brought about by the action of light—is due to the ultraviolet, rather than to the visible rays of the spectrum. As a matter of fact, subsequent investigation has confirmed the view that some ultraviolet radiations possess this biologic action, for when they are filtered out from the spectrum the rays lose this power.[3] As is well known, the composition of the rays of the sun is not at all times the same. There is a marked seasonal variation in its spectrum—in the temperate zone the rays are incomparably richer in ultraviolet during the spring and summer than they are during the winter months.[4] In view of this seasonal variation of the ultraviolet rays, and in view of the pronounced effect of ultraviolet radiation on the inorganic phosphate of the blood, it seemed worth while investigating whether the transition of the seasons led to periodic chemical alterations. The infants who were tested were from 6 to 18 months of age, living under excellent hygienic conditions, and were on a diet of certified raw milk or of dried milk, as well as the usual amount of orange juice, the older ones receiving cereal in addition.

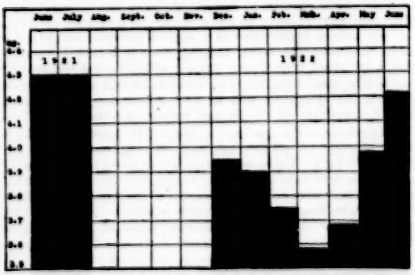

Chart 1.—Seasonal tide of blood phosphate (inorganic).

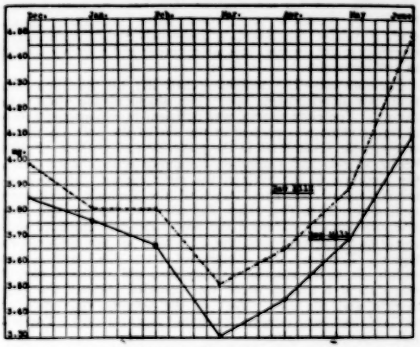

Chart 2.—Seasonal tide of blood phosphate; diets, raw milk and dried milk.

Chart 1 illustrates the result of this study. It will be noted that in the summer of 1921 the phosphate content of the blood was 4.34 mg. per cent., which is within the normal for the Bell and Doisy method. Further data were not available in 1921 until December, when it was found that the average had fallen to 3.92 mg. per cent. Monthly examinations, some 300 in all, comprising about sixty infants, demonstrated a steady decrease of the inorganic phosphate, the lowest ebb being in March. This level would have been still lower had it not been for the fact that whenever the phosphate content was found to be low (3.75 mg.) the child was given either sun treatment or irradiation from an artificial source. In fact, it was found that the blood test furnished a valuable criterion as to when heliotherapy should be instituted. In April the tide began to rise, ascending markedly in May, and rising to almost a normal level during June.

It is probable that this seasonal tide, with its summer flood and winter ebb, occurs to a greater or less degree in most bottle-fed infants living in the large cities.

1. Hess, A. F., and Gutman, F.: The Cure of Infantile Rickets by Sunlight as Demonstrated by a Chemical Alteration of the Blood, Proc. Soc. Exper. Biol. & Med. **19**: 31, 1921.
2. Hess, A. F., and Unger, L. J.: Use of the Carbon Arc Light in the Prevention and Cure of Rickets, J. A. M. A. **78**: 1596 (May 27) 1922.
3. Hess, A. F.; Pappenheimer, A. M., and Weinstock, M.: A Study of Light Waves in Relation to Their Protective Action in Rickets, Proc. Soc. Exper. Biol. & Med. **20**: 16, 1922.
4. This distinction is not due to a difference in quality of the rays themselves, but is an absorption effect resulting from the inclination of the sun and the average absorption coefficient of the atmosphere due to varying weather conditions. The ultraviolet portion of the sun's spectrum is much more sensitive to such changes than the red, and the altitude of the sun occasions a much greater relative difference in the degree of absorption.

These babies were outdoors every fine day for a few hours, bundled up in the usual fashion, with only a portion of their faces uncovered. Their diet was far better than the average; about half received certified milk, in an endeavor to ascertain whether this high grade of milk possessed advantages over the cheaper pasteurized milk which is in general use. A glance at Chart 2 will show that the phosphate tide is not intimately dependent on the variety of milk, and that it was pronounced when the raw certified milk was fed, although the level was somewhat higher than when dried milk was given. It may be added that the diet was either full milk, or formulas containing two-thirds milk, so that the intake of calcium and of phosphate was high. We are unable to state how breast-fed infants react to the influence of season: whether they also manifest a tidal blood variation. Judging, however, from the fact that 50 per cent. of well nourished breast-fed infants attending an outpatient department have been found to show clinical evidences of rickets at the end of March,[5] it seems probable that they, likewise, are susceptible to seasonal fluctuations.

In somewhat older children the variations were found less marked. In a group of ten children, from 2 to 3 years of age, on a mixed diet containing milk, broth, cereal, vegetables, etc., the inorganic phosphate fell in March to 3.89 mg.; in June it rose to 4.2 mg. per cent. The rise was definite, however, in every instance. A small number of tests were carried out on adults, for the most part on the medical staff and their assistants. The inorganic phosphate of the blood, as is well known, is normally lower in adults than in infants. Our examinations showed that it is also far more stable. The figures for June did not vary appreciably from those in March, the average being 2.9 mg. at both seasons; moreover, individual idiosyncrasies were maintained at both periods.

that the ultraviolet rays are the main cause of its seasonal variation. It is quite possible that other climatic factors and meteorologic conditions play a rôle, but they would seem to be of minor importance. The accompanying table gives meteorological data taken in New York City (Central Park) covering the period of the tests for blood phosphate. This information was kindly furnished by the New York Meteorological Observatory. An examination of these figures shows that the most constant seasonal alteration during this period was in the actual amount of sunshine. A study of this table shows that the course is very similar to

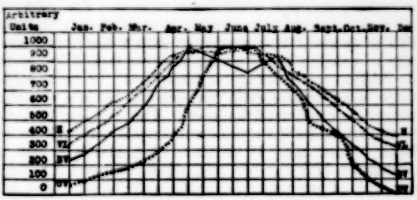

Chart 3.—Seasonal variations of the sun's spectrum: *H*, solar heat; *V L*, visible light; *B V*, blue violet; *U V*, ultraviolet.

that of the blood phosphate, decreasing during the winter months and beginning to rise in the latter half of March. In a relationship of cause and effect we should expect the increase in sunshine to precede by a few weeks the augmentation of the inorganic phosphate. There was also a mean daily elevation of temperature beginning at this period, so that this factor may play a rôle in the chemical change. The relative humidity runs such an irregular course that the change in the blood phosphate cannot be ascribed to this phenomenon.

METEOROLOGICAL DATA COVERING PERIOD OF PHOSPHATE TESTS

	1921				1922					
	June	July	Nov.	Dec.	Jan.	Feb.	March	April	May	June
Mean daily maximum temperature	81.2	85.5	50.8	39.9	34.4	40.9	48.8	60.7	75.1	79.9
Mean daily minimum temperature	61.1	66.8	38.6	25.5	21.9	26.2	33.2	42.2	54.0	63.6
Mean daily temp. (average of maximum and minimum)	71.1	77.3	44.7	32.5	28.2	33.6	41.0	51.4	64.6	71.8
Relative humidity (mean hourly)	61.3	75.6	74.4	62.8	59.0	65.7	63.8	56.8	62.2	75.7
Dry bulb temperature (Fahrenheit; shade; mean hourly)	70.3	76.1	44.3	32.1	28.1	33.3	40.6	50.9	63.5	70.7
Wet bulb temperature (shade; mean hourly)	61.2	69.9	40.8	29.4	24.6	29.9	36.6	43.7	55.3	65.0
Precipitation (snow and rain; total for the month)	2.79	2.62	3.81	3.64	12.13	10.55	9.42	2.02	3.76	6.88
Mean barometer (average of 7 a.m., 2 p.m., 9 p.m.)	29.807	29.830	29.88	30.005	29.992	29.951	29.956	29.864	29.845	29.805
Mean vapor pressure (average of 7 a.m., 2 p.m., 9 p.m.)	0.458	0.658	0.297	0.129	0.160	0.194	0.174	0.219	0.356	0.535
Dry bulb temperature (exposed to sunlight)	90.0	97.0	58.4	50.9	51.5	53.9	62.3	77.1	91.2	90.3
Actual sunshine (total hours for the month)	327.3	271.1	116.0	171.6	173.4	144.3	209.0*	279.2	337.1	266.4
Cloudiness (scale 0-10; during daylight)	4.6	6.3	7.3	5.5	5.4	6.6	6.3	5.5	4.6	6.9
Prevailing wind (direction)	S.W.	S.W.	N.E.	N.W.	N.W.	N.W.	N.W.	W.N.W.	W.S.W.	W.N.W.
Mean daily wind movement (miles)	211.6	186.0	267.7	248.6	294.2	264.1	290.3	262.7	225.9	203.2
Average daily wind velocity (miles an hour; Dines anemometer)	8.8	7.8	11.2	10.3	12.3	11.0	12.1	11.0	9.5	8.5
Average daily maximum wind pressure (Dines anemometer)	2.13	1.36	3.09	3.12	3.71	2.90	3.15	2.91	2.39	2.05

* During first half of March, 81.4 hours; during second half, 127.6 hours.

As has been stated, the ultraviolet rays of the sun vary markedly with the season. This is particularly well illustrated by a graph of Dorno (Chart 3), a composite of observations carried out at Davos, Switzerland. It shows the small amount of ultraviolet radiation in the winter, its rather sudden increase in the late spring, its flood during the summer, and its gradual fall during the autumn months. This curve resembles essentially the graphs of the inorganic phosphate content of the blood which are portrayed in Charts 1 and 2, and lends added weight to the opinion

These meteorological observations confirm our opinion that the dominating factor in the phosphate tide is sunlight, an opinion which is strengthened by the fact that an increase of blood phosphate was brought about during these winter months simply by irradiations of ultraviolet light supplied by an artificial source (carbon arc).[5] In this connection it is well also to bear in mind that rickets and tetany are almost nonexistent in the tropics.

As referred to elsewhere,[6] ultraviolet light is not only able to raise to the normal a lowered inorganic phosphate content of the blood, but also to perform

5. Hess, A. F., and Unger, L. J.: Infantile Rickets: The Significance of Clinical, Radiographic and Chemical Examinations in Its Diagnosis and Incidence, Am. J. Dis. Child. **24**: 327 (Oct.) 1922.

6. Hess, A. F.: Influence of Light in the Prevention and Cure of Rickets, Lancet **2**: 367 (Aug. 19) 1922.

the same service in respect to calcium when it is diminished. We have encountered numerous instances in which a low percentage of about 7 mg. has been increased to more than 10 mg. by irradiations for from two to three weeks with the carbon arc light. Only an extensive study can determine whether this reaction indicates that there is likewise a seasonal tide in infants of the calcium of the blood. In general, our figures for calcium are somewhat lower for the early spring than for June. The greater stability of calcium, however, as compared to the inorganic phosphate of the blood, would lead us to expect far less fluctuation.

As is well known, one of the disorders that manifest a striking seasonal incidence is tetany. The peak of its incidence occurs somewhat later in the spring than that of rickets. It is associated with a diminished content of calcium in the blood, which is especially low in its relation to the inorganic phosphate. In many cases there is an inverse ratio between the calcium and the phosphate content of the blood. This relationship may be illustrated by the case of an exceptionally well nourished infant, aged 11 months, who, March 8, had a content of 12.5 mg. per cent. of calcium and 3.54 mg. per cent. of inorganic phosphate in the blood. May 22, these amounts had changed to 7.55 mg. for calcium and 4 mg. for phosphate; the calcium had fallen markedly, whereas the phosphate had risen. Carbon arc irradiation was then given, and by June 8 the calcium had risen to 10 mg. and the phosphate to 4.58 mg. per cent. In other words, with the marked fall of the calcium in May there was a concomitant rise of phosphate. Such occurrences, which are not exceptional, suggest that the seasonal increase of phosphate, beginning in April and ascending still higher in May, tends in some cases to the development of tetany late in the spring.

This seasonal variation evidently indicates that the chemical constitution of our blood is not constant for all periods of the year; this probably holds true for other tissues. Marked fluctuations of this character may be discovered only in young children, in whom the body has to make provision not only for the metabolism associated with maintenance, but also for that demanded by rapid growth, a mechanism which necessarily involves a tendency to wider deviations from the normal. It is quite possible that "the phosphate blood tide" is only one of many seasonal variations that take place in the body. This aspect of metabolism has not been the subject of investigation, but it would seem to be a promising field, and a systematic study of the blood from various points of view—chemical, immunologic, etc.—might well be undertaken on animals and on man, and may reveal unknown seasonal peculiarities. In this connection, a variation in the iodin content of the thyroid gland of animals may be referred to. Some years ago, Seidell and Fenger [7] showed that the average iodin content of the healthy thyroid gland of sheep, of cattle and of hogs is, in general, about three times as large for the months from June to November, as for the months from December to May. Another investigation which borders on this subject is that of Reid Hunt,[8] who found that guinea-pigs were decidedly more resistant to acetonitril poisoning in the spring and summer than in the winter, and who concluded that this difference probably was associated with some seasonal variation in metabolism.

Undoubtedly climatic conditions exert a pronounced influence on general nutrition. For many years, clinicians have insisted on the obscure but definite relationship between seasonal changes and certain pathologic disorders, although scientific medicine could not substantiate their empiric observations. A striking example of the fundamental influence of the seasons on normal nutrition, and one which is subject to mathematical verification, is the seasonal periodicity of growth in length which is manifested in childhood. The investigations of Malling-Hansen and of others have shown that children grow far more rapidly in the spring and summer than during the winter months. Such seasonal activity is all the more significant when we bear in mind the fundamental character of the impulse required to bring about growth in length.

It is quite possible that chemical alterations of the tissues, induced by seasonal meteorological variations, may exert an influence not only on nutrition, but also on infection. For example, the low content of inorganic phosphate that occurs in the early spring and is closely associated with rickets may play a rôle in the susceptibility to infection which accompanies this disorder. Furthermore, seasonal alterations of the blood many bear a relationship to the vagaries in incidence of the epidemic diseases, and should be considered in connection with epidemiologic studies on animals and on man.

16 West Eighty-Sixth Street.

7. Seidell, A., and Fenger, F.: Seasonal Variation in the Iodine Content of the Thyroid Gland, J. Biol. Chem. 18: 517, 1913.

8. Hunt, Reid: The Effects of a Restricted Diet and of Various Diets upon the Resistance of Animals to Certain Poisons, Bull. 69, Hyg. Lab., U. S. P. H. S., 1910.

MANAGEMENT OF HEAD INJURIES WITH REAL OR POTENTIAL BRAIN DAMAGE

WITH SPECIAL REFERENCE TO THE VALUE OF SATURATED SOLUTIONS OF MAGNESIUM SULPHATE AND SODIUM CHLORID

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During the last year, the relatively large number of cases of head injury admitted to the Grady Memorial Hospital (colored division) has afforded an unusual opportunity to work out a definite policy in the management of such cases, and one attended with a degree of success justifying this review.

CLASSIFICATION OF CASES

We have learned to classify cases of head injury thus:

A. Massive brain injury, with evidence of rapid exhaustion of the medullary centers, and death within one to several hours after admission.

B. Definite evidence of middle meningeal hemorrhage.

C. Simple or compound depressed fracture, with localized brain contusion, with or without indriven bone fragments.

D. Classic manifestations of rapidly increasing intracranial pressure which are well within the period of medullary compensation.

E. Definite evidence of brain injury exhibiting no classic findings of acutely increasing intracranial pressure, yet of the type that experience has shown is liable to develop gradually increased intracranial pressure due to fluid accumulation.

F. So-called "concussion" with no evidence of gross brain damage.

G. Depressed fracture of a mild degree, giving rise to no symptoms whatsoever.

H. Scalp lacerations, without damage to the underlying structures.

TREATMENT OF DIFFERENT CASE GROUPS

Before determining the type of treatment, we attempt, as far as possible, to classify the case. In many cases, the eventual decision may be delayed until the patient has been observed for several hours.

A classification under A, B, C or H can usually be readily determined and a decision promptly made as to what should be done. From two to six hours of careful observation is usually necessary before the other classes of cases can be properly estimated.

Class A. These cases are of such a nature as to render any effort without avail. Operation is without value and is distinctly contraindicated. Death invariably results within a few hours, no matter what is done.

Class B. Here, an immediate operation is indicated. A straight incision such as is used in a typical subtemporal decompression is made on the involved side. The temporal muscle is separated in the direction of its fibers and retracted to either side. The skull is entered with perforator and burr, disclosing to view the large epidural clot. As soon as the diagnosis has been thus confirmed, and before enlarging the opening in the skull and removing the clots, the external carotid artery should be ligated through a small neck incision. By this precaution, much time will be saved and continued troublesome hemorrhage from the torn meningeal artery prevented. The intracranial ligation of the artery under such circumstances is not always an easy matter. After the external carotid artery has been ligated, the craniotomy can be safely continued. The bone is removed for a diameter of from 5 to 7 cm., and the large epidural clot thoroughly removed. As a further precaution against the possible occurrence of increased intracranial pressure, the dura should be opened by means of crucial incisions. The overlying structures are now carefully closed with several layers of interrupted fine silk sutures.

Class C. In these cases the best results are obtained, if the technic of débridement (with certain modifications) advised by Cushing in the operative handling of war injuries is employed. The edges of the lacerated scalp are cut away; the underlying bone injury is exposed; all bone fragments are carefully removed and placed in sterile salt solution, and, by means of catheter-suction, all contused brain and blood clots are carefully removed. The dural opening is now closed, if possible, and the bone defect covered with such of the removed bone fragments as are suitable. The scalp wound is now carefully approximated with interrupted fine silk galea and skin sutures. If it seems advisable to give the brain room on account of increased intracranial pressure, a typical subtemporal decompression can now be done. As a rule, this will not be necessary.

Class D. These cases usually have more or less laceration of the temporal lobe, with accumulation of blood intradurally. The choice of treatment is still a source of much argument among neurologic surgeons. I myself am of the opinion that the best chance of recovery for these patients is offered by a subtemporal decompression, with or without temporary drainage by means of a small wick of rubber tissue placed under the temporal lobe and escaping through the lower angle of the wound. Occasionally, bilateral decompressions may be indicated. There is, of course, much room for argument for and against operation in this class of cases. I have adopted the operative treatment in this particular type of injury during the last ten years and I feel convinced that the results have justified the method.

Class E. It is to this class of patients that I wish to call particular attention. The patients are usually brought into the hospital in a semiconscious condition. The blood pressure as a rule is somewhat higher than normal, but does not gradually increase as in Class D. The roentgen ray usually reveals linear fractures of varying degrees, and the spinal fluid is often blood tinged. One feels safe in assuming that there has been definite gross brain damage, although there is no rapidly increasing intracranial pressure. Such cases under the usual method of treatment (absolute rest in bed and application of an ice cap to the head) are liable, within a few days, to show definite signs of increased intracranial pressure, not infrequently of such an alarming character as to call for energetic treatment. If these patients are operated on when symptoms of increased intracranial pressure develop, there is usually found a large collection of blood-tinged fluid under the dura, but apparently none in the subarachnoid space. Why this fluid should be between the arachnoid and dura is an interesting question. A plausible explanation is that, at the time of injury, the arachnoid is ruptured in different areas so that the cerebrospinal fluid does not remain in the subarachnoid space, from which it would probably be absorbed, but escapes directly under the dura, where cerebrospinal fluid absorption is impossible. When this fluid is allowed to escape at operation, the brain mass, instead of being swollen and edematous, seems at times to be actually decreased in volume. Drainage, for several days, usually relieves the distressing symptoms of increased intracranial pressure.

In our experience, the foregoing sequel to the injury can be prevented, provided the patient is given the proper treatment soon after being admitted to the hospital. Weed and McKibben [1] have shown experimentally that the pressure of the cerebrospinal fluid and the bulk of the brain can be reduced by the intravenous injection of hypertonic salt solution. Foley and Putnam [2] demonstrated experimentally that hypertonic saline solution given by mouth likewise reduces cerebrospinal fluid and brain bulk, although the action is much slower than when saturated sodium chlorid solution is given intravenously. The clinical uses of salt solution in conditions of increased intracranial tension have likewise been discussed by Foley.[3]

In an effort to prevent the accumulation of fluid, with the resulting symptoms of increased intracranial pressure in this class of cases, we now administer a saturated solution of magnesium sulphate by mouth as a routine measure in all cases in which immediate operation is apparently not indicated. One-half ounce of the solution is given every two hours (the dose being decreased in proportion in children) for the first twenty-four to forty-eight hours. Thereafter, the time of administration is lengthened to every three hours for a day or two, and then gradually decreased accord-

1. Weed, L. H., and McKibbon, P. S.: Am. J. Physiol. **48**: 512 (May) 1919.
2. Foley, F. E. B., and Putnam, T. J.: Am. J. Physiol. **53**: 464 (Oct.) 1920.
3. Foley, F. E. B.: Clinical Use of Salt Solution in Conditions of Increased Intracranial Tension, Surg., Gynec. & Obst. **33**: 126 (Aug.) 1921.

ing to the condition of the patient. After from seven to ten days, the drug is usually withdrawn entirely. If at any time evidences of increased pressure develop in spite of the magnesium sulphate, the treatment is supplemented by the intravenous injection of 30 per cent. sodium chlorid solution. This, however, has been necessary in only a very few cases falling in this group. Although occasionally magnesium sulphate poisoning occurs, in our series of cases there has been no illustration of such an effect of the drug. However, on account of this danger, we have considered putting a series of patients on sodium chlorid tablets coated with phenyl salicylate in order to determine whether or not the same beneficial results are obtained.

As evidence of the value of this routine measure, in no case in this series has operative drainage of the fluid become necessary. All cases ran an uneventful course and the patients left the hospital apparently well within three weeks after admission. On the other hand, in several cases seen in consultation and in which no hypertonic solution had been given, the classic picture of increased intracranial pressure was present, necessitating energetic treatment in order to combat the distressing symptoms. As an illustration of this type of case, I wish to mention briefly a recent experience:

V. S., a man, received a head injury, Sept. 12, 1922, resulting in unconsciousness which lasted thirty-six hours. His condition then became satisfactory, according to the attending physician, and remained so until September 20, when he began to show symptoms of increased intracranial pressure. September 22, he was admitted to the hospital in the general surgical service. He was kept in bed with ice cap to the head, but had no other treatment. September 29, I saw him in consultation. The picture presented at this time was practically that of the terminal stage of increased intracranial pressure. There was marked bilateral choking of the disks, stertorous, irregular breathing, rapid pulse, absence of knee reflexes and relaxation of sphincters. In general, the picture was such that one hesitated to advise operative treatment. Fifty cubic centimeters of a 30 per cent. sodium chlorid solution was given intravenously, with an appreciable improvement in the condition. Thirty cubic centimeters of the hypertonic solution was administered intravenously six hours later, and continued every six hours during the following thirty-six hours. At the end of this time, the picture presented was quite different in every respect. The patient was conscious; the pulse was 100; respiration was even and regular, and voluntary swallowing was possible. A saturated solution of magnesium sulphate in one-half ounce doses was then ordered by mouth every three hours. Within five days, the patient seemed securely on the road to recovery. Ten days after administration of the hypertonic solution had been instituted, the patient was normal in all respects, except the choked disks, which gave evidence of subsiding. October 20, the patient left the hospital, apparently normal in every way.

Class F. To this class of cases belong those who have a history of a slight blow on the head followed by temporary unconsciousness. After a few hours, these patients become mentally clear, and careful neurologic examination fails to reveal any evidence of gross brain damage. The spinal fluid is clear, and there is no particular alteration of the pulse, blood pressure, or respiration. Such cases are usually kept under careful observation for about three days, in order to be sure of the diagnosis. Rest in bed and free purgation with salines is the treatment indicated. If there is such a thing as real concussion of the brain, I feel that this particular class of cases should be the type referred to when such a diagnosis is made.

Class G. Not infrequently, patients with simple depressed fracture of the skull presenting no symptoms whatsoever, are admitted to the hospital. It is an open question whether or not these patients should be operated on. I feel that, as it is a simple matter to elevate such fractures and to investigate the structures underlying the depression, the safest policy is to operate in these cases as a matter of routine. Not infrequently, there will be found a certain amount of localized brain contusion underlying these fractures. When such a condition exists, a simple débridement by means of suction, followed by closure of the dura and replacement of the bone fragments, I believe to be the treatment of choice.

Class H. In treating the average case of scalp laceration, it is extremely important to determine whether or not the underlying structures are damaged. If not, the edges of the lacerated wound should be trimmed away and the wound closed with interrupted fine silk sutures. These wounds when so treated invariably heal by primary intention.

The value of hypertonic solutions in surgery of the brain has been proved by many observers (Haden,[4] Cushing,[5] Sachs[6]). It is not my purpose to discuss the various conditions in which they are beneficial. In my work I give saturated magnesium sulphate solution in varying doses, as a routine measure, after all cranial operations in which I feel that acute increased intracranial pressure may occur owing to fluid accumulation. When this condition already exists, I prefer the more rapid action of saturated sodium chlorid solution, intravenously.

CONCLUSIONS

1. All head injuries should be carefully studied and the type of injury properly estimated before the institution of any particular treatment.

2. No treatment is of avail in those cases of massive brain injury presenting evidence of rapid exhaustion of the medullary centers.

3. The treatment of middle meningeal hemorrhage can be greatly facilitated by ligating the external carotid artery.

4. The technic advised by Cushing in the treatment of war wounds of the skull and brain should be used in the treatment of those cases of brain injury in which there is localized brain contusion.

5. Subtemporal decompression is still the treatment of choice in cases of brain injury when there is evidence of gross brain laceration, and the patients are yet well within the so-called period of medullary compensation.

6. Saturated magnesium sulphate solution by mouth will prevent the occurrence of increased intracranial pressure due to fluid accumulation and thereby prevent the necessity of late operation in many cases of brain injury in which immediate operative intervention does not seem to be indicated.

7. Saturated solution of sodium chlorid intravenously is of inestimable value in relieving acute increased intracranial pressure due to fluid accumulation occurring several days after head injuries, with definite brain injury.

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4. Haden, R. L.: Therapeutic Application of Alteration of Brain Volume by Injection of Glucose, J. A. M. A. **73**: 983 (Sept. 27) 1919.
5. Cushing, Harvey, and Feley, F. E. B.: Proc. Soc. Exper. Biol. & Med. **17**: 217, 1920.
6. Sachs, Ernest, and Belcher, G. W.: Use of Saturated Salt Solution Intravenously During Intracranial Operations: Preliminary Report, J. A. M. A. **75**: 667 (Sept. 4) 1920.

THE STATUS OF THE NEGATIVE WASSERMANN REACTION *

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Probably because of the protean character of its manifestations, there is no disease presenting more inherent difficulties in its management than syphilis, and there are few in which more terrible and well-nigh inexcusable errors have been committed. This may be maintained as to both diagnosis and treatment, and it is to a realization of these facts, reenforced by the enormous increase in our general knowledge of the disease that, perhaps, we owe the evolution of the syphilologist.

In spite of the fact that the condition is one that requires the most expert and skilled management if its complete control is to be attained, for reasons that are apparent a large proportion of cases will always be cared for by the man in general practice.

Much emphasis has been laid on the vital importance of an early diagnosis and the prompt initiation of treatment; much has been written concerning the dangers of a premature dismissal from treatment; and it is inevitable that much prominence—deservedly—has been given to the significance of the Wassermann test in both connections.

It is permissible to question whether or not the utility of the complement-fixation test has at times, perhaps, been unduly distorted when considering the positive reactions, and whether or not sufficient emphasis has been laid on the proper evaluation of a negative Wassermann reaction in its relation to diagnosis and treatment.

It is inevitable that, with or without his willingness and accord, the general practitioner must accept the responsibility of the care of a certain proportion of syphilitic patients. He owes it, therefore, to both himself and his patients, and it becomes a moral necessity not to be avoided, to handle them wisely and scientifically. For that reason he must be prepared to interpret correctly and utilize intelligently the Wassermann test as a diagnostic and therapeutic aid.

It may be taken for granted, perhaps, that the significance of a positive Wassermann reaction is known and understood; but it can be debated whether the value and the significance of a negative Wassermann reaction are grasped with equal clarity and confidence. It can safely be maintained that, in many instances, the reliance placed on a single negative reaction as an indication of the absence of syphilis is too great, is unwarranted, and is the direct cause of untold misery as being responsible for a high proportion of intractable, though avoidable, complications.

With these thoughts as a premise, it seems of interest to consider, briefly, the consensus of thought as to the significance of a negative Wassermann reaction, and the factors influencing its evaluation in both the diagnosis and the treatment of syphilis.

Some consideration of the rationale underlying the complement-fixation test in syphilis is unavoidable because of its direct bearing on the point at issue.

Although the exact and detailed mechanism of the test has yet to be discovered, much information of value has been elicited, even though it be mainly of negative character.

The nature of the substance or substances—conveniently spoken of as reagin—concerned in the reaction is still unknown. The bulk of the evidence at hand seems to indicate that they are of lipoid character and that the reaction is, most likely, of a chemical nature in which colloids play a large part. Nor is the exact source or mode of production of these bodies as yet made clear: whether they arise from the action of the spirochetes on the cells of the tissues; whether they are entirely an expression of cellular reaction to the activities of the spirochetes; whether the activities of the spirochetes per se play a part in their production, or whether all these factors are interrelated all being matters still held sub judice.

Regardless of their exact origin, however, it is plain that their presence represents a reaction of the body in some fashion to infection with spirochetes, and it is apparent, therefore, that many factors are concerned as influencing their presence, their production, and the amount in which they may be found.

It becomes obvious, therefore, that while the occurrence of a positive Wassermann reaction when properly checked and controlled is well-nigh indisputable evidence of the presence of syphilitic reagin and hence of syphilitic infection, by no means the same reliance can be placed on a negative reaction as indicative of the absence of syphilis, for reasons hereafter indicated.

In the first place, it must be recognized that there are limits to the delicacy of the Wassermann test. This is in part dependent on the inherent character of the reaction, and in part directly related to details of technic. The latter factor may give rise to such marked variations in delicacy as to render it advisable for the clinician to familiarize himself with the general principles of the test so as to be in a position to estimate the relative efficiency of the method used by his serologist.

Secondly, regardless of the source or exact mode of production of the reagin, it is clear that, because it represents a reaction to infection, the rapidity and intensity of production will be influenced by the individual capacity of the patient to react, as well, perhaps, as by the virulence and aggressiveness of the infecting strain. Furthermore, there must necessarily be an indeterminate period, possibly influenced by all these factors, which must elapse before reagin can be produced and appear in the blood in amounts sufficient to be detected by methods of ordinary delicacy.

It is also of great importance to have in mind the fact, as yet inexplicable, that in known syphilis, without treatment, sudden and spontaneous variations in the strength of the reaction may occur so that, without apparent cause, a strongly positive reaction may become weaker and even, temporarily, negative.

RELATION TO DIAGNOSIS

With these general premises as a starting point, the negative Wassermann reaction may be considered in its relation to diagnosis.

Primary Syphilis.—As might be foreseen from the consideration of the factors influencing the production of reagin, its occurrence in detectable amounts in the blood stream is in direct proportion to the age of the lesion.

While delicate antigens, such as the cholesterinized extracts, will not infrequently give a positive reaction as early as seven days after the appearance of the chancre, as a general rule it can be said that it is unsafe to expect the appearance of a positive Wassermann reaction before the twenty-first to the thirtieth day in

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primary syphilis. A negative Wassermann reaction before this time in the presence of a suspicious lesion is of no diagnostic value, and cannot be relied on as a basis for dogmatic assumptions.

It may not be amiss, here, to digress momentarily to emphasize that any genital lesion is suspicious; all are to be looked on as chancres until shown to be otherwise, for experience has shown that the "typical" chancre is rare and that a differential diagnosis between abrasion, chancre and chancroid by means of gross physical characteristics is often impossible and cannot be relied on. There is only one certain method of distinction: the dark field illuminator. If, as is frequently the case, salves or washes have been used and the spirochetes thus driven from the surface, examination of the fluid secured from a regional lymph gland may be successful. This is easily done by the injection and reaspiration of a small amount of sterile physiologic sodium chlorid solution.

In the early days of a chancre, then, the dark field illuminator is the method of choice and solely to be relied on for diagnosis, the Wassermann reaction being of little value. The longer the time between the appearance of the lesion and the examination, the less are the chances of success with the microscope and the greater become the possibilities of the Wassermann test.

It is inexcusable in these days, when the vital importance of prompt treatment has been so conclusively shown, to wait for the appearance of secondaries; and to rely on the "therapeutic test" is a confession of ignorance or laziness or both.

If, however, the Wassermann test is of no diagnostic value in the first three or four weeks of the disease, a negative Wassermann reaction is of decided prognostic value during this period, since experience has shown that the patients in whom treatment is begun before the appearance of the Wassermann reaction present the greatest hope of ultimate and complete cure.

It is advisable, therefore, in the examination of a suspicious patient, while relying on the microscopic demonstration of the spirochetes for diagnosis, to take a Wassermann test for its aid in estimating the probable result of treatment.

Secondary Syphilis.—In secondary syphilis the disease is well advanced and, as evidenced by the character of the lesions, generalized, systemic invasion has occurred. It is logical, therefore, to expect the concomitant appearance of reagin in the blood and body fluids, and this expectation is confirmed by the high percentage of cases (from 92 to 100) in which a positive Wassermann reaction occurs.

A negative reaction, therefore, may be regarded as indicating the nonsyphilitic character of suspected lesions with a marked degree of certitude. It should always be the rule, however, to confirm the reaction by another when in doubt.

Tertiary Syphilis.—As in this stage of the disease a positive reaction is found in from 90 to 96 per cent. of untreated patients, and in from 75 to 80 per cent. of patients who have had more or less treatment, a negative reaction is of decided value.

This is a favorable place in which to emphasize that the results of the Wassermann test—or any other method of examination—must always be interpreted in terms of the individual patient, and the occurrence of a negative reaction must never be allowed to overshadow the presence of suggestive clinical findings. If, however, in a suspected case the test is repeatedly negative, especially when performed by different observers, the nonsyphilitic character of the lesions is very probably assured.

Cerebrospinal Syphilis.—While in this class of cases the Wassermann test is positive in a high proportion, it must not be overlooked that a definite number of such positive reactions will be with cholesterinized antigens, the cholesterin-plus reaction, other antigens being negative. This must be noted because, in the absence of fixation with other antigens, the cholesterin-plus reaction is looked on as without significance by some workers, and may therefore be reported as negative.

Also it must be remembered that occasionally in cerebrospinal syphilis the blood serum may be entirely negative while the spinal fluid is strongly positive, a condition probably due to the fact that antibodies pass from the blood to the spinal fluid only with great difficulty, the reagin being probably confined to the subarachnoid space.

In any event, the absence of cerebrospinal syphilis cannot be stated with certainty until a negative Wassermann reaction is secured with the spinal fluid, and such a negative reaction can be taken as very reliable evidence of the absence of syphilitic reagin.

Congenital Syphilis.—While the Wassermann test has been a valuable source of information and a valuable aid in the discovery of congenital syphilis, it is important to remember that the results are to a marked degree influenced by the time at which the examination is made.

It has been demonstrated that a considerable number of syphilitic infants may show a negative Wassermann reaction at birth and only react positively months later. It is advisable, therefore, when either of the parents is known to be syphilitic, to repeat the test on the child at 3, 6 and 9 months of age. If the reaction remains consistently negative, the probabilities are largely in favor of the infant's remaining free from congenital syphilis.

In untreated congenital syphilis in children 1 year of age or over, the test is positive in from 97 to 100 per cent. of cases, so that a negative reaction under these circumstances is of decided value and largely to be relied upon.

Latent Syphilis.—In this condition the spirochetes may often be dormant with consequently little tissue destruction and therefore only small amounts of reagin present, so that a negative reaction is of little significance.

For the proper evaluation of a negative Wassermann reaction in its relation to the diagnosis of syphilis, therefore, certain desiderata are necessary:

1. The test must be carefully and accurately made and intelligently applied to the study of the individual case.

2. The specimen must be secured with a clear realization of the various factors influencing the result of the examination.

3. The result of the test must be interpreted in conjunction with all the other findings in the case at hand.

4. A single negative reaction must not be allowed to overshadow other suspicious or suggestive data, and is best corroborated by subsequent repeated examinations.

THE NEGATIVE WASSERMANN REACTION IN ITS RELATION TO TREATMENT

The Wassermann test, at present, is virtually the only guide available for estimating the efficiency of treatment, and it is in this connection, perhaps, that undue

value and reliance has been placed on a negative reaction, the result of attributing too great a significance to a single test and too little importance to technical details. It has been shown beyond question that in determining whether or not treatment can be safely discontinued, unless the test includes a cholesterinized antigen, implicit reliance cannot be placed in a single negative result.

Certain general principles must be adhered to if the Wassermann test is to be—as it must be—intelligently utilized as a guide to treatment.

1. A negative Wassermann reaction is of no value and has no significance if the test is made while the patient is still under medication. The specimen cannot safely be taken until from three to four weeks have elapsed after the cessation of treatment.

2. Treatment can never be safely discontinued until a negative reaction has been obtained with a cholesterinized extract.

3. A single negative reaction is not to be relied on as indisputable evidence of complete cure. It must be reenforced and corroborated by further negative reactions at appropriate intervals before the permanent absence of syphilitic reagin can be assumed.

4. A negative result occurring during or shortly after the ingestion of large amounts of alcohol is of no significance.

It may not be amiss here to discuss briefly the relation of the negative Wassermann reaction to the determination of the cure of syphilis. Much has been written in the past, and many caustic shafts have been leveled at the domination of the treatment of syphilis by the Wassermann test, but time tells its story and the increasing weight of experience has rendered the test well-nigh impervious to assault. Syphilis is a curable disease under certain conditions, but it is a wise man or a rash one who assumes the ability to tell when it has been cured. As far as can be ascertained, there are only three criteria by which the absolute cure of syphilis can be determined: (1) the contraction of a new chancre; (2) a persistently negative Wassermann reaction with both blood and spinal fluid, coupled with (3) the absence of symptoms of any kind.

We now know that, in a high percentage of so-called "Wassermann-fast" cases, cerebrospinal symptoms develop; persistent efforts are therefore indicated to make the Wassermann reaction negative.

The negative Wassermann reaction is the only available, reliable evidence at hand to determine the absence of reagin and consequently of interaction between the spirochetes and the tissues at the time of the test, and a single negative reaction is of no value per se as indicating the permanent absence of reagin.

The only safe plan to follow in deciding whether or not a sufficiency of treatment has been administered in a given case may be thus outlined:

1. After the completion of two courses of treatment (arsenicals and mercury), a Wassermann test should be made one month after treatment has been stopped.

2. If this is negative, no further treatment should be given, and the test should be repeated at the end of the third month following the cessation of treatment.

3. If this is negative, the test should be again repeated at the end of six months and one year after the cessation of treatment.

4. In the second year, the test should be repeated at least twice.

In addition, since we now know that involvement of the central nervous system occurs early rather than late in the disease, there is a growing opinion that no case should be dismissed until a negative spinal fluid Wassermann reaction has been obtained.

If consistently negative Wassermann reactions have been secured during the foregoing period, the patient may be dismissed from observation with a fair degree of safety; but he must be earnestly impressed with the necessity of having his Wassermann reaction taken at two or three year intervals during the remainder of life, if without symptoms, and at once if suggestive symptoms appear.

CONCLUSION

A negative Wassermann reaction is of value only when intelligently interpreted in conjunction with the other findings; a single negative reaction is of little value in the presence of suggestive clinical findings; and as evidence of cure, a single negative reaction is worthless.

SPONTANEOUS PNEUMOTHORAX: REPORT OF CASE, WITH RECOVERY

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Pneumothorax of the spontaneous type is of apparently rare occurrence. In conversation with many busy practitioners and with specialists in diseases of the chest, I found none who could recall having seen a case. Osler[1] states that it is an extremely rare condition and that, almost invariably, it is associated with serous fluid or pus. I feel, therefore, that this case should be reported both for its interest in itself and in order that the records may be amplified.

In the majority of the reported cases, spontaneous pneumothorax has been associated with some severe effort. In many instances, however, as in the one now reported, the condition has developed under ordinary circumstances and while the victim was at rest. It occurs usually in young adults and more commonly in males. In most of the cases there is no previous history of pulmonary disease. The onset is sudden and is usually accompanied by pain in the affected side, urgent dyspnea, cough and cyanosis. In most instances the severe symptoms last but a few days, and, after from eight to ten weeks, the air is completely absorbed. The physical signs in a typical case offer an easy means of diagnosis. Should there be any doubt, a roentgenogram is very characteristic.

The treatment in these cases should be merely symptomatic and by no means meddlesome. Absolute rest will usually relieve all the unpleasant symptoms. Should the dyspnea become severe, however, aspiration must at once be proceeded with; otherwise death from suffocation may result. The tear in the lung may act as a valve, allowing the air to rush in and then preventing its return. In the reported instances, no bad effects were noted from tapping. There was instant relief, with no return of the pneumothorax. The prognosis in all cases attended by recovery from the immediate effects is for a complete recovery.

REPORT OF CASE

History.—Nov. 13, 1919, J. F. R., a minister, aged 30, was referred to me by Dr. Walter Reedy, a laryngologist, who had been consulted by the patient because of dyspnea. Dr.

1. Osler, William: Textbook of Medicine.

Reedy, after an examination, made a diagnosis of pneumothorax of the left chest. The family history in the case was negative to tuberculosis, as both parents, three brothers and two sisters, all adults, were in good health. Twelve years previously, after a ride in the cold, behind a team, the patient had developed a pain in the left back so severe that he was unable to use the arm on that side. After three weeks, he felt completely well. This attack was probably an acute pleuritis. Four years before the present illness, he had a gastric disturbance, when the diagnosis of chronic appendicitis was made. At the same time, he had night sweats for a few months. Then followed a breakdown, which kept him from his studies for a short period. This he attributed to the effects of the indoor seminary life after he had been active in athletics for years. For the last few years, he had had pain in the region of the left shoulder. This pain could usually be "worked out." In later attacks, it spread to the region of the sixth and seventh ribs, beneath the left scapula, and each time had grown more severe. Immediately preceding the onset of his illness, he was unusually active and was in the habit of taking hard drives over country roads.

November 10, at 7 a. m., without any unusual effort and with no warning, the attack came on as the patient was dressing. The feeling was as of the sudden passing of gas from the stomach, filling the left back, then crossing to the front of the chest and descending to the base. There followed a period of unproductive coughing. He was unable to bend his body forward, and in order to pick up anything he was compelled to get down on his right side by flexing the knees. There was no real pain at the time, or any sense of suffocation. Later, however, there was a choking sensation, as if he were suffering from lack of air. An hour after the onset, he held services, but he could not preach because of the oppressive feeling in his chest. He had a mission several miles away; and, during the ride there in the buggy, he was compelled to sit sideways and be careful to avoid any jarring. Three hours after the onset, such excruciating pain came on that with every breath he was forced to grunt. The pain was unlike any he had ever experienced. In another hour, he held his second service; and he felt so well that he preached as usual. The nervousness and restlessness that had seized him now cleared up and his confidence returned. He ate well and retired early, but that evening could not sleep because of a sense of foreboding. He remained in the country on the following day, but on the third day came to the city for medical advice.

Examination.—The patient, who was referred to me on the fourth day of his illness, was well nourished and muscular, with a chest markedly well developed. His appearance was that of one under some physical strain. The face was slightly cyanosed, and he had a dry, irritating cough and some difficulty in breathing. When his clothes were removed, it was evident that there was no movement of the left chest, not even on deep inspiration. On the left side, tactile fremitus was completely absent and the apex beat could not be felt. The percussion note was markedly hyperresonant over the entire left chest, including the precordial area. Breath sounds were everywhere absent, and the vocal fremitus was greatly diminished. The heart sounds could be heard only under and to the right of the sternum, and the rate was 78. The coin sound could not be elicited. The right lung was negative, and the liver was not felt below the costal margin. The diagnosis of left-sided pneumothorax, made by Dr. Reedy, was confirmed, and a roentgenogram taken that afternon showed a complete left pneumothorax with the lung collapsed toward the hilus and no sign of fluid. In the right lung, a few small calcified spots appeared in the upper lobe and about the hilus.

The patient looked well and experienced few ill symptoms. From his appearance, the extent of the lesion would never have been suspected. The slight cyanosis and dyspnea, with no rise in temperature and a pulse rate a few beats above normal, gave no hint of the true condition.

Course.—The patient was sent to a hospital and put at complete rest. November 19, the tenth day after the onset, some movement of the left chest was detected, and rough, crumbling breath sounds could be heard over the upper lobe. At the same time, he experienced a sensation as of slight irritation in the left lung. From then on, the lung gradually expanded until, November 30, he had improved to the extent that breath sounds were everywhere heard distinctly, but at a distance, and vocal fremitus was increasing. The physical signs now resembled those met with in a thickened pleura, with the exception that the percussion note was hyperresonant. At the base in the midaxillary line, there was a small area into which the lung had not yet entered. The apex beat had returned to almost the normal position. A second roentgenogram by Dr. Jackson, December 3, showed a small amount of air in the pleural cavity at the base and the lung almost in complete expansion.

December 10, while out for a short walk, the patient felt a sudden pain in the left chest, radiating upward into the neck and down into the abdomen. He was very much frightened, as the pain was not unlike that felt at the onset of his attack. His surprise was great when he was informed that the lung had not again collapsed. On examination, however, a small area of flatness, about 3 inches (7.5 cm.) in diameter, had appeared at the base, in the midaxillary line. Under the fluoroscope, a small amount of fluid could be seen. For a few days, the effusion spread, then gradually disappeared, until at the end of ten days there was no sign of it. Its appearance was accompanied by no rise in temperature or pulse rate. In all likelihood, the pain was due to the lung expanding suddenly to all limits, and the effusion was consequent on the friction of the two pleural layers.

Outcome.—About Jan. 1, 1920, the patient felt so well that he was anxious to resume his duties. His strength had never been affected, and the pain and dyspnea had disappeared. Fluoroscopic and physical examinations revealed no sign of pneumothorax or effusion, but a thickening of the pleura posteriorly was apparent. Although urged to rest and to be extremely careful at least until spring, he disregarded the advice and took over an active service. For many months afterward, there appeared on occasions a return of the old deadening pain beneath the left scapula, but of late this has abated. The patient is now in excellent health, and on examination practically no difference in the two lungs can be found.

Three weeks after the onset, the patient was seen by Dr. Joseph Walsh of Philadelphia, and the roentgenograms were examined by him and by Dr. Pancoast. Their opinion was that the pneumothorax was due to the tearing of an old adhesion from the pleurisy of ten years before. They noted that a portion of the lung did not collapse about the seventh rib posteriorly, owing very likely to adhesions that did not break.

SUMMARY

A case of pneumothorax occurring in a healthy person under ordinary circumstances was likely due to the breaking of an adhesion from an old pleuritis. The hole in the lung closed in four hours, after which there were few unpleasant symptoms. There was no accompaniment of effusion or fever. In ten days the breath sounds began to return, and in three weeks there was almost complete expansion. The patient returned to his duties in two months. A recent physical and fluoroscopic examination shows a lung with complete return of function except for a slightly lessened expansion.

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Rabies in Portugal.—The *Medicina Contemporanea* gives the figures from the Lisbon and the Paris Pasteur institutes since 1893 for comparison. They show that the number of persons applying for treatment has constantly declined in Paris, from 1,648 in 1893 to 330 in 1913; the number since has risen a little. In Portugal, the number has increased from 367 in 1893 to 1,562 in 1913. Since then it has increased to 4,249 during the first six months of 1922. The mortality in Paris has ranged from zero to 0.5 and at Lisbon from zero to 0.82, but since 1913 it has not been above 0.15 at Paris and 0.32 at Lisbon. Lisbon has had five zero years to Paris' four, between 1893 and 1915.

FLAGELLATE INFESTATIONS AND INFECTIONS

GIARDIASIS, OR LAMBLIASIS; TRICHOMONIASIS; PROWAZEKIASIS, CERCOMONIASIS, CHILOMASTIXIASIS AND TETRAMITIASIS

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Because of the apparently increasing interest in the United States in the flagellates, and in compliance with numerous requests, a brief summary of the problem has been prepared from my Philippine records. No attempt is made to consider the biology of the parasites, because that is well done in a number of publications on parasitology.

LAMBLIASIS,[1] OR GIARDIASIS

The synonyms of the term lambliasis, or giardiasis, are flagellate diarrhea (in part), tropical diarrhea (in part) and monad diarrhea (in part). It may be defined as an infection or infestation, principally of the intestine, by *Lamblia intestinalis* (R. Blanchard, 1888), characterized by chronic diarrhea with intermittent acute exacerbations, digestive disturbances and nervous symptoms, or by the presence of the parasites without symptoms. *Lamblia intestinalis* is one of the common parasites, and lambliasis one of the common diseases, of the tropics. The intestinal or usual form of the disease is noted more than 1,500 times in my hospital records, and it is much more frequently encountered in ambulatory patients. It is, and has been for years, recognized by clinicians in the tropics as a disease of importance, particularly in children; and experimental reproduction and other research work are attracting more attention to it in temperate climates.

Predisposing Causes.—Infestation with *Lamblia* is cosmopolitan. Evidences of infection, with the production of harmful symptoms, is somewhat more restricted, and appears to be influenced by a number of factors, some of which at least are known. Tropical climate and the summer weather of the temperate zone favor the infestation and development of infection in carriers. Children are especially susceptible, and the infection is more severe in them than it is in adults. In the tropics, the infection is relatively higher and more severe among foreigners than among the native races. The presence of other diseases or debility from any cause is a noticeable predisposing factor. Other intestinal infections appear to predispose to lambliasis; but this probably is due to the frequent common sources of the various infecting agents, a fact which also explains the frequency of mixed infections.

Exciting Cause.—The disease is an infection by *Lamblia intestinalis*, acting alone or in conjunction with other somewhat similar parasites. For discussion of the biology of the parasite, any of the numerous books on animal parasites may be referred to. The methods of invasion and the pathogenicity for and locations in the human host may be discussed here. It is generally considered that the parasite has no free living cycle. Its transmission, therefore, must be directly or indirectly from one host to another; and there is ample evidence that such are the methods of transmission to the human host. The direct method from infected excretions to the mouth probably is important, particularly in children. Grassi infected himself with the cysts; and, recently, well controlled experiments have proved the practicability of this method of infection. The cysts are thrown off in great numbers in the discharges from infected persons and from animals, such as rats, rabbits and mice; but the duration of their infectivity under these conditions is not known, and therefore the indirect methods of transmission may not be accurately predicted. Stiles and Keister consider the carrying of the spores from infected discharges to food by the common house fly the most important method of transmission. These authors believe that *Lamblia* found in animals is a distinct species and that human infection is dependent on transmission directly or indirectly from a human host. Some students accept the specific identity of the human and animal *Lamblia*, and thus greatly broaden the infective opportunities.

It is generally recognized, and has been experimentally demonstrated in some cases, that water, vegetables, cereals and other foods may be contaminated with spores or encysted forms from the discharges of infected persons or animals, and that new infections occur through eating such infected substances. It has been suggested that the spores may be transmitted through the air, in dust, as is known to be the case with certain other parasites. The occasional infestation of the respiratory tract appears to strengthen this view as to a possibly practical method of transmission. In the vast majority of instances, invasion is through the mouth; but the occasional finding of the cysts in bronchiectatic secretion suggests possibilities of entrance through the respiratory system. The parasites are most numerous in the intestine, but have been found in the mouth, in vomited material, and in the discharges from liver abscesses which have been operated on. The pathogenicity of *Giardia* for the human host now is generally accepted, and certainly there can be no question of its disease-producing properties, at least under certain conditions. This fact is supported by numerous reports from various countries, and has been experimentally proved by inoculation, originally by Grassi on himself, and since that time by other investigators. Mice also have been infected by feeding the cysts of *Lamblia* from infected human discharges.

The principal argument against the pathogenic properties is the frequent presence of the organisms in persons without symptoms of disease. This argument formerly was applied to many bacterial and parasitic diseases, from cholera to amebiasis. Such an argument needs no reply, in the light of our present knowledge of infections and immunity.

Pathology.—The nature of the lesions and the methods by which they are produced are difficult to determine because (1) death rarely results from the pure *Lamblia* infection; (2) mixed infections are the rule, and (3) lesions found at necropsy may be due to or influenced by the associated parasites and bacteria. Such evidence as is available indicates that the parasites produce a catarrhal condition of the mucosa of the small intestine, and that either primarily or as secondary invaders they aggravate lesions of the intestine caused by other agents. It is not unlikely that the unknown cysts or egglike bodies sometimes encountered in sections through amebic and other intestinal lesions may be *Lamblia*. In their flagellate stage, the parasites probably are limited to the small intestine in distribution, except in diarrhea, when active forms frequently are seen in feces. Encysted forms are more or less constantly present in the formed stools when the small intestine is infested. That the cysts may reach

1. Although probably not zoologically correct, the word lambliasis is used for historical and sentimental reasons.

more distant organs is shown by their presence in the contents of liver abscesses.

Symptoms.—Lamblia may be transiently present in the stools of persons showing no symptoms of disease. If permanent parasitism may be established without symptoms, it must be exceptional, depending on the many explanations of similar cases of infection with other pathogenic organisms. We have encountered no instance of prolonged parasitism without symptoms. The characteristic and usual symptoms of intestinal infection are a chronic diarrhea, with exacerbations and intermissions, during which there may be constipation, very much as is seen in amebic colitis. There is nothing distinctive about the diarrhea except its persistence and the difficulty in obtaining a permanent cure, particularly in children. The stools are of the usual type; and in severe cases there may be some tenesmus and blood, but this is exceptional. Microscopically, there is mucus, usually blood cells and either motile or encysted *Lamblia*. The parasites usually are quite numerous when the diarrhea is severe, and during intermissions only a few or no cysts may be found after prolonged search. In a child under my care for a pure infection of *Lamblia* for more than two years, and who was finally sent to the United States because of the persistence of the disease and the consequent anemia and lack of development, there were frequent periods of six or seven weeks when there would be no diarrhea, and only a few cysts could be found in the stools. Such intermissions invariably were followed with exacerbations of acute diarrhea, usually with some blood, and the specimens would contain myriads of the motile *Lamblia* organisms. More or less indigestion is usual in the well established cases, and occasional nausea and vomiting is not rare. The nervous symptoms complained of are irritability, insomnia and occasional headache. Infections elsewhere than the intestine, such as in the lungs, stomach and liver abscess, are so rare and so frequently associated with other diseases that they are only mentioned.

Diagnosis.—This is based on the persistent presence of *Lamblia* in the diarrheal stools for which there is no other logical cause. In the mixed infections with other flagellates, so often seen, *Lamblia* may be considered the most important causative agent. Diagnosis should not be made on a single examination, for obvious reasons.

Prognosis, Prophylaxis and Treatment.—The infection usually is a chronic one, particularly in children, and very resistant to treatment. Among foreign children in the tropics, where it shows its greatest intensity and persistence, it may be necessary to advise a change to a temperate climate in order to secure recovery. Public health measures consist in the proper disposal of feces, and the destruction of flies, rats, mice and other animals known to harbor the parasites. Important personal measures consist in using safe drinking water, avoiding uncooked food, and maintaining scrupulous cleanliness about the discharges, particularly where there are children. There is no known specific remedy. Various drugs, such as turpentine, ipecac, emetin, quinin, methylene blue, arsphenamin, arsenic and thymol, have been used intravenously, internally or by enema. Enemas are useful when there is diarrhea, and for this purpose a 1:2,000 solution of thymol has given me the greatest satisfaction. It is, of course, impossible to reach the breeding ground of the parasites in the small intestine by local methods. Of all internal remedies, thymol in 0.25 to 0.5 gm. doses given in capsule with lactose has given me the best results. General measures to conserve the patient's strength and control the diarrhea are indicated.

TRICHOMONIASIS

Trichomoniasis may be defined as an infestation or infection of the intestine, less frequently of the stomach, mouth, air passages, vagina, bladder and other organs, by species of the genus *Trichomonas*, characterized by no definite symptoms or by those due to local irritation.

Species of *Trichomonas* are among the most cosmopolitan and widespread parasites infesting man. Opinions regarding their influence in the causation of disease vary from the belief that they are entirely harmless, to the other extreme, in which they are charged with responsibility for severe dysentery and other pathologic conditions. The weight of evidence appears to attach slight importance to them when in small numbers in otherwise healthy persons, and to consider that their etiologic importance increases when in large numbers, or in persons already debilitated from other causes, or when, as usually is the case, they are associated with other parasites.

Etiology.—Infestations and infections with symptoms are reported from many countries. However, both infestation and the prevalence of disease symptoms are more frequent in the tropics. Children are more susceptible than adults, and the debilitated more so than the healthy. Foreigners are more likely to show symptoms of infection than are natives of the tropics. The biology of the various species of *Trichomonas* is not considered here. They are usually classed as strict parasites of man and other animals, with an encysted stage during which they are transferred directly or indirectly from one host to another. They usually enter directly into the digestive tract, but may be found in the respiratory passages, the vaginal and urinary canals and elsewhere. For convenience, the disease may be discussed as intestinal, respiratory and genito-urinary.

Intestinal Trichomoniasis.—This is the usual type and the one of most importance. As determined by stool examination, the percentage varies between 10 and 75, or more, of the inhabitants in different tropical localities. The number of persons harboring the parasites who show diarrhea or other symptoms which may reasonably be charged to the infection varies from 10 to 50 per cent. of all classes, and is much higher among those heavily infected. *Trichomonas intestinalis* is the species usually present, but various other closely allied flagellates frequently are associated with it. The pathogenicity of *Trichomonas* in diarrheal conditions is pretty generally accepted by experienced clinicians in the tropics, though not by all. Some even credit it with being the cause of dysentery among children. Mello-Leitao considers primary trichomoniasis, either alone or with *Lamblia* infections, the most common form of dysentery among children in Rio de Janeiro; and Escomel reports 152 cases of dysentery from the same cause in Peru. Derrieu and Raynaud report it from Algeria; Brumpt, in a patient from Tonkin, and many other observers from various places recognize the disease-producing properties of these flagellates. Lynch believes that *Trichomonas* found in the intestine, mouth, lungs and vagina is the same organism, and that it excites existing inflammatory conditions. He was successful in infecting rabbits both from cultures of the parasites and from infected secretions.

Symptoms.—The symptoms of intestinal infection are diarrhea, usually not severe, worse in the morning and accompanied by flatulence and more or less indigestion. There may be moderate secondary anemia, and usually there are nervous symptoms, such as irritability, insomnia and headache. Not infrequently *Trichomonas* occurs in the stomach as well as the intestine, and usually is associated with pronounced symptoms. One of the most interesting reports in this connection is that of Frank Smithies' two cases. In both of these, constipation was present instead of diarrhea. Other prominent symptoms were nausea, flatulence, abdominal distention, colicky pains, headache, neuralgia and exhaustion. Smithies suggests that the cleavage products of protein contained in large numbers of these parasites may be a not inconsiderable influence as (1) a gastro-intestinal irritant; (2) an altering metabolic change in digestive glands, or (3) a source of so-called intoxication symptoms, clinically.

Treatment.—The treatment is the same as that already given for lambliasis. The parasites are difficult to remove, and appear both by microscopic examination and by clinical symptoms to exhibit a periodicity in numbers, as is true of most pathogenic parasites. Vigorous special treatment is not indicated in the absence of symptoms.

Respiratory Trichomoniasis.—This type has been reported by a number of observers who consider the parasites pathogenic in the air passages, especially following some injury. Dolley reports a case of gangrene of the lung in which large numbers of *Trichomonas* were the apparent cause. They have been discovered in bronchiectatic sputum, and reported in cases of chronic bronchitis. Steam inhalations of creosote and terebene caused the disappearance of the flagellates, and was followed by recovery in two cases of bronchiectasis in my service. There is no method of determining the pathogenic rôle of the parasites in these cases, but, as in the gastro-intestinal type, their disappearance usually is simultaneous with improvement in the patients.

Genito-Urinary Trichomoniasis.—Trichomonas vaginalis is frequently found in the vaginal canal in women residing in the tropics. The same or a similar species is found in the female bladder and, rarely, in the male bladder. Those from the bladder usually are found in the urine, indicating more or less cystitis; but the part played by the flagellates in its production has not been sufficiently studied.

TETRAMITIASIS; CHILOMASTIXIASIS; CERCOMONIASIS; PROWAZEKIASIS

Flagellate protozoa belonging to these genera and species, and perhaps others not yet classified, are found inhabiting chiefly the intestine and occasionally other parts of the human body. Their distribution is widespread as parasites of man, several lower animals and invertebrates. Their association with diarrhea and other disease symptoms in man is cosmopolitan, but, as in the case of *Giardia* and *Trichomonas*, the highest incidence of infestation and the most frequent association with symptoms are found in the tropics. The methods of invasion are similar to those already described for *Lamblia*, which is by direct or indirect transmission of the cysts or spores from the discharges of one host to the digestive canal of another. This may take place directly by faulty personal hygiene, or indirectly by infected food and water or by flies, or perhaps even wind may carry the spores. The most interesting and important point in connection with these infections is the question of pathogenicity of the parasites, and here there is the widest difference of opinion. Some authorities consider the parasites harmless; but the weight of evidence among men working in warm countries assigns pathologic importance to them, at least under conditions of mass invasion of the parasites or decreased resistance on the part of hosts. Marques da Cunha and Torres consider *Chilomastix* the cause of chronic diarrhea in children in Brazil, and Gobel reports similar conditions in Tunis.

The symptoms and treatment of intestinal infections, which are the only ones of medical importance, are similar to those already described for *Lamblia*.

If the common parasites discussed briefly in this paper do not have pathogenic significance, they certainly "are an awful lot in bad company."

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VITAMINS IN ICE CREAM*

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The study of the vitamins in ice cream has two points of value. In the first place, it adds an important item of a statistical nature to the evidence which is still accumulating concerning the accessory food factors; for the already large consumption of ice cream in the United States is on the increase, and popularity of the frozen sweet is bound to spread to other countries. Secondly, through the experiments here reported, one may estimate the effect of pasteurization and of freezing and storage on the vitamins in such a mixture as ice cream.

The plan of the experiment was to test the ice cream for the various accessory food factors before freezing, and to repeat the tests on the same mixture after freezing. White rats were used in the tests for vitamins A and B, the technic of Ferry [1] being followed. For the antiscorbutic vitamin, the procedure of Sherman, Lamer and Campbell,[2] with the following diet, was employed: soy bean meal (autoclaved), 83 per cent.; filter paper pulp, 3 per cent.; cod liver oil, 5 per cent.; dried yeast, 3 per cent.; calcium lactate, 3 per cent.; sodium chlorid, 3 per cent.

When the frozen ice cream was used as the source of the accessory food substance, it was first melted on the water-bath, care being taken that the temperature of the mixture did not rise above that of the room. Plain vanilla ice cream containing 10 per cent. butter fat was employed throughout the experiments.

VITAMIN A

Two kinds of protein were used in the diets for vitamin A study. One, casein-Merck, which had been heated in air at 105 C. for twenty-four hours and then extracted with hot alcohol and ether, contained traces of the fat soluble factor, with the result that the animals grew for from four to eight weeks at a subnormal rate and usually developed ophthalmia while still making this slow gain. On the other protein, casein-Harris, which was prepared from a good grade of commercial casein by dissolving in caustic alkali, and filtering sparkling clear, reprecipitating and wash-

* From the Sheffield Laboratory of Physiological Chemistry, Yale University.

1. Ferry, E. L.: J. Lab. & Clin. Med. 5:735 (Aug.) 1920.
2. Sherman, Lamer and Campbell: J. Am. Chem. Soc. 44:165, 1922.

ing repeatedly with alcohol and ether, the rats gained for a very short time or not at all, the cessation of growth occurring without evident ophthalmia. In all cases, if loss of weight on diets low in the A factor was allowed to proceed longer than a week, pulmonary affections, sore feet, diarrhea and extreme emaciation followed, and death could not be prevented by feeding vitamin A. It is important, in such feeding experiments, to give the source of vitamin A when the animal has merely ceased growing on the vitamin-low diet rather than after decline in weight has definitely set in.

Mendel [3] has reported that 100 mg. of butter fat daily will provide fat soluble vitamin for growth to maturity of a rat on otherwise adequate diet. In the present series of experiments, 1 gm. and 0.5 gm. a day of the unfrozen and of the frozen ice cream, respectively, were fed in different experiments. When 1 gm. of ice cream (100 mg. of butter fat) furnished the sole source of vitamin A, normal growth was obtained. The same was true of the unfrozen mixture. When, however, 0.5 gm. of ice cream (50 mg. of butter fat), either frozen or unfrozen, was fed, subnormal growth was obtained. Here, then, is evidence that freezing has no effect on the growth-promoting power of the fat soluble vitamin and, basing our statement on Mendel's figures for butter fat, the preliminary pasteurization of the unfrozen mixture at 180 F. for one-half hour had no marked deteriorating effect on vitamin A in the mixture.

Rats, with ophthalmia of varying degrees of severity, on a diet low in fat soluble vitamin were cured by 1 gm. daily of either the unfrozen or the frozen ice cream. The ophthalmia in two rats was cured with as little as 0.25 gm. of frozen ice cream a day, which represents 25 mg. of butter fat. Growth was not obtained with this quantity of ice cream, however, until the eyes were entirely clear, and then the animals grew only at a subnormal rate.

VITAMIN B

Milk has not been considered a rich source of the water soluble vitamin. American investigators have never been able to duplicate the results with the small dosages found adequate by Hopkins.[4] Osborne and Mendel [5] obtained normal growth to maturity with 16 c.c. of fresh milk as a minimum. In ice cream, the milk and possibly the eggs used constitute the source of vitamin B. In the present series of experiments, 7.7 gm. of either the unfrozen or the frozen ice cream (equivalent to 15 gm. of milk) was the minimum satisfactory amount for normal growth, and some rats required 10.2 gm. (equivalent to 20 gm. of milk). Doses of both the unfrozen and the frozen ice cream equivalent to 5 and 10 gm. of milk were found to be distinctly inadequate as a source of vitamin B for inducing normal growth.

VITAMIN C

The potency of milk as an antiscorbutic varies with the feed of the cows and the treatment of the milk. The obscure history of the milk used in commercial ice cream and the pasteurization of the mixture raises doubt as to the value of the product as an antiscorbutic. Again, the high calorific value of the ice cream mixture prevents the ingestion of the large amount theoretically necessary even when resorting to forced feeding. Doses equivalent to 60 c.c. of milk were given, but as soon as scurvy developed the guinea-pigs refused to eat this amount. Guinea-pigs on the soy bean diet usually showed the first clinical signs of scurvy in from fourteen to sixteen days. When the animals were forced to eat the ice cream, the first appearance of the disease was delayed for one to seven days. Apparently, the animal was sustained by the forced feeding long enough for severe scurvy to develop; for classic clinical and postmortem pictures of the disease were obtained in practically all of the animals. Lack of appetite, lethargy, bloody diarrhea, prolapse of the rectum, sore joints and muscles, costochondral enlargements, sore eyes and loose teeth were observed, and on necropsy, extensive hemorrhages under the muscle sheaths and in the joints, gums and costochondral junctions.

Neither frozen nor unfrozen ice cream in the maximum doses possible caused more than the slightest delay in the appearance of scurvy. In no case was protection afforded.

SUMMARY

Vitamin A was present in the typical samples of ice cream in such concentration that one may conclude that no noteworthy alteration in its potency is caused by pasteurizing or freezing. Normal growth was induced by 1 gm. of the ice cream, and ophthalmia was cured by 0.25 gm., containing 25 mg. of butter fat.

The vitamin B of the ice cream can be accounted for by the equivalent quantity of milk used in it. Freezing had no effect on the vitamin B in the ice cream used. The ice cream, which was made from pasteurized products, contained no significant quantity of vitamin C.

3. Mendel, L. B.: New York State J. Med. **20**: 212 (July) 1920.
4. Hopkins: J. Physiol. **44**: 425, 1912.
5. Osborne, T. B., and Mendel, L. B.: J. Biol. Chem. **34**: 537 (June) 1918.

INFLUENCE OF DIET ON BLOOD GROUPING *

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Since their discovery by Landsteiner and Shattock, working independently in 1900, isohemagglutinins have been studied extensively by Hektoen, Ottenberg, Moss, Jansky, Gay, Brem and many others. Their practical application in blood transfusion requires no comment here. During this time, the investigators have uncovered many interesting and practical facts in regard to the character and mechanism of these isohemagglutinins. Among the influencing factors may be mentioned heat, desiccation and disease. No reference in regard to diet as a definite factor in this respect has been noted.

We believe that diet does play a part in influencing isohemagglutinins, especially in Group III blood, and that it should be taken into consideration to avoid untoward results. The question of diet was brought to our attention in the following manner: This laboratory, like others, keeps on hand for blood grouping purposes the serums of Groups II and III. The serums are obtained from the laboratory personnel. Occasionally, difficulty was experienced in securing a Group III serum that was high in isohemagglutinin or was of good keeping quality, notwithstanding the fact that the same blood had yielded an excellent serum on a previous occasion.

* From the U. S. Naval Medical School.

Then, again, it was noticed that, in attempting to group such a blood, unsatisfactory results were encountered: the cells of this Group III blood would not properly agglutinate with a definite Group II serum; so that, unless one was alert, a Group III would be classified as a Group I (Jansky) or a Group IV (Moss). This difficulty was never experienced with groups other than Group III. Several instances occurred in which a donor, classified under Group I (Jansky) or Group IV (Moss) was subsequently found to belong to Group III. The error was detected by a direct match with a recipient's blood which was a definite Group I (Jansky) or Group IV (Moss). When this occurred, inquiry always revealed that the Group III subject had been on a diet insufficient in greens. This led to a more or less empiric policy of placing men of Group III on a diet rich in greens before using their serums for grouping purposes. The results obtained were excellent.

TABLE 1.—ORDINARY DIET

		Group II (Serum)	Group III (Serum)
Group I (Cells)..	A.	No agglutination	No agglutination
	B.	No agglutination	No agglutination
	C.	No agglutination	No agglutination
		Group II (Serum)	Group III (Serum)
Group II (Cells).	D.	No agglutination	Strong agglutination
	E.	No agglutination	Strong agglutination
	F.	No agglutination	Strong agglutination
		Group II (Serum)	Group III (Serum)
Group III (Cells).	G.	Weak agglutination	No agglutination
	H.	Weak agglutination	No agglutination
	I.	Weak agglutination	No agglutination

TABLE 2.—GREEN-FREE DIET

		Group II (Serum)	Group III (Serum)
Group I (Cells)..	A.	No agglutination	No agglutination
	B.	No agglutination	No agglutination
	C.	No agglutination	No agglutination
		Group II (Serum)	Group III (Serum)
Group II (Cells).	D.	No agglutination	Strong agglutination
	E.	No agglutination	Strong agglutination
	F.	No agglutination	Strong agglutination
		Group II (Serum)	Group III (Serum)
Group III (Cells).	G.	Very weak agglutination	No agglutination
	H.	Weak agglutination	No agglutination
	I.	Very weak agglutination	No agglutination

TABLE 3.—GREEN DIET *

		Group II (Serum)	Group III (Serum)
Group I (Cells)..	A.	No agglutination	No agglutination
	B.	No agglutination	No agglutination
	C.	No agglutination	No agglutination
		Group II (Serum)	Group III (Serum)
Group II (Cells).	D.	No agglutination	Strong agglutination
	E.	No agglutination	Strong agglutination
	F.	No agglutination	Strong agglutination
		Group II (Serum)	Group III (Serum)
Group III (Cells).	G.	Strong agglutination	No agglutination
	H.	Strong agglutination	No agglutination
	I.	Strong agglutination	No agglutination

* Jansky classification is used. Group IV (Jansky) or Group I (Moss) is not available. The technic is essentially that of Lee and Minot as described in "The Principles of Immunology" by Karsner and Ecker. Letters A, B, C, etc., refer to men of each group.

In order to arrive at a definite conclusion, three men each of Groups I, II and III (Jansky) or IV, II and III (Moss) were grouped and placed on a green-free diet for a period of four days, and again grouped. These men were then placed on a diet consisting of a large quantity of greens for four days, and grouped again. The results are shown in the accompanying tables.

It will readily be seen that the grouping of the Group III Cells was influenced to a remarkable degree. It cannot be said, however, that there was a definite change of group.

SUMMARY

1. Diet apparently influences the serum of Group III blood.

2. Diet apparently interferes with the proper agglutination of cells of Group III blood in Group II serum.

3. As we were handicapped by lack of sufficient material, the series is, as we realize, entirely too small to form a basis for definite conclusions. However, we consider these findings sufficiently practicable to stimulate investigation along this line.

THE DIAGNOSIS OF EPIDEMIC ENCEPHALITIS *

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Epidemic (lethargic) encephalitis is one of three important inflammatory, nonsuppurative diseases of the central nervous system which have certain features in common. Each regularly, at least in the more severe cases, affects to some degree the whole cerebrospinal axis and its meningeal coverings; but there is nearly always a maximal involvement of some particular portion which determines the principal symptomatology in any given case. The other two diseases to which I refer are acute poliomyelitis and syphilis. To distinguish the three diseases from one another and from other diseases, it will be helpful to bear in mind a few of their salient pathologic features.

POLIOMYELITIS AND ENCEPHALITIS

Poliomyelitis and encephalitis both affect the interior of the nervous organs more than the meninges, and gray matter more than white matter. In both we have collars of inflammatory cells about blood vessels; but neither tends to cause occlusion of the blood vessels. The meningeal inflammation is slight and only microscopic in both, but more marked in poliomyelitis; hence the greater tendency to meningitic signs, such as Kernig's sign and stiff neck and back, in poliomyelitis. Each disease really is poliencephalomyelitis, but one principally affects the brain and the other principally the cord. Hence there is little difficulty in distinguishing between the two if we have a pure brain picture or a pure cord picture.

There is a place, however, where brain and cord meet, namely, the medulla oblongata; and with an acute inflammation there, producing an acute bulbar paralysis, we are often at a loss when it comes to making a diagnosis. If the patient should live long enough, the appearance of atrophy, reaction of degeneration, and residual flaccid paralysis of the affected muscles would almost settle the diagnosis in favor of poliomyelitic infection, as the less severe inflammation caused by the encephalitic virus rarely causes sufficient destruction of ganglion cells to produce these sequels.[1] But the patient usually dies in a few days, and as there are no

* Read before the Englewood Branch of the Chicago Medical Society, Nov. 7, 1922.

1. However, localized degenerative muscular atrophy in an unusual case of epidemic encephalitis also complicated by optic neuritis has been described by Julius Grinker: J. Nerv. & Ment. Dis. 52:123 (Oct.) 1920.

distinguishing laboratory tests, we are left to guess. I have seen several such cases; those occurring in summer I called poliomyelitis, those in winter encephalitis, and when I saw one in the fall I just held up my hands. Necropsy was refused, but it is by no means certain that histologic examination would have settled the question. Very likely there would have been too little ganglion cell destruction for typical poliomyelitis, perhaps a trifle too much for typical encephalitis, while the perivascular inflammation which undoubtedly would have been present is common to the two.

Even with the main symptoms relating to the pons and ocular nerve nuclei in the midbrain the same doubt may exist, and only the addition of symptoms referable to the basal ganglions will settle the diagnosis in favor of the encephalitic virus. There have been whole epidemics of such borderline cases, particularly the famous one in Australia, where the nature of the infection remains unsettled. Even animal inoculations on a large scale do not always settle the question, as the disease produced may also be betwixt and between, and the globoid bodies or pleomorphous streptococci likely to be encountered may be claimed for either disease. Neutralization experiments with a known virus might be helpful, but they are laborious and very expensive.

SYPHILIS

Syphilis does not so often produce clinical pictures resembling encephalitis. However, there are a few reports of cases of syphilitic inflammation of the midbrain in which the clinical resemblance was very close.[2] The most interesting point connecting these two diseases is the apparent existence in encephalitis as well of a "para" stage, i. e., of progressive cerebral disease coming on long after the acute illness, and separated from it by an apparently normal interval. This is particularly true of the postencephalitic parkinsonian syndrome. It is probably not yet known by all physicians that this condition may come on long after the acute illness which often was so mild that it is forgotten, so that it is necessary to ask the patient about it. I have seen many cases in which a diagnosis of previous acute encephalitis could be positively made by the character of the subsequent affection, just as the nature of a doubtful and, at the time, trivial venereal lesion many years later is made clear by the appearance of tabes or paresis. I have now under my care a young woman who had a rather mild acute attack, recovered, married, and had a child. Then she gradually developed a severe parkinsonian syndrome so that she even became unable to feed herself and walk. Another case is that of a stenographer, aged 26, who had a typical and rather severe attack in February, 1919. There was a general tremor at first, and it persisted in the left foot for about half a year. Then she was perfectly well until July, 1921, when the tremor reappeared in the left leg. It was typically parkinsonian, present with the foot at rest, suppressed during voluntary movement. A third case is that of a professional man, aged 38, who came to me a few days ago with a constant side-to-side tremor of one foot, of a few months' standing, of parkinsonian type, and no other symptoms. He told me that he had a mild attack of influenza two years before; he did not have to go to bed, but stayed at home several days because of double vision, which was the first and the most troublesome symptom. Of course, what he had at that time was a mild acute encephalitis.

If we are not aware that a long normal interval may intervene, we shall make the mistake of regarding these patients as victims of true paralysis agitans. To be sure, such a mistake is not so very serious as the treatment is virtually the same, and in these late forms the resemblance both as to character of tremor and as to progressiveness of course to true paralysis agitans is closer than in cases in which the parkinsonian syndrome develops during the acute stage and persists as a sequel. In these late recurring cases the onset of tremor and rigidity is usually very gradual, and there is no reason to assume that a fresh infection from without has taken place. The view is gaining ground that the virus, like that of syphilis, may remain dormant for years, and then give rise to a more chronic and degenerative process than the one encountered in the typical disease. Necropsy returns from old and prolonged cases begin to come in and substantiate this view. In a case of two years' standing, König [3] found in the corpus striatum proliferation of neuroglia and calcareous deposits in the small vessels. In the pons and medulla he found glial proliferation, invasion of ganglion cells by phagocytes, and perivascular infiltrations of plasma cells and lymphocytes. In this country, Globus and Strauss [4] have described a primarily subacute form in which early diagnosis is extremely difficult. Four such cases were examined postmortem, and the most striking change consisted of proliferation of the adventitia of vessels and organization of new connective tissue and new blood vessels—in other words, changes quite similar to those of the late stages of syphilis. This view, that the so-called sequels are really manifestations of a chronic and often progressive process, has the support of such exeperienced investigators as von Economo in Vienna and Netter in Paris. The other view has been that the acute disease may leave lesions behind in the basal ganglions analogous to those produced by illuminating gas and manganese poisoning, with the later tissue changes purely degenerative and secondary, and no active virus or toxin operating. Another resemblance between encephalitis and syphilis is the occurrence of the Argyll Robertson pupil. While not common in the former disease, it certainly is encountered.

SEQUELS

Several rare conditions may be sequels of acute encephalitis, and their presence may lead to a retrospective diagnosis of the original infection. I may mention so-called hypophysis syndromes with adiposis, polyuria and genital atrophy,[5] myasthenia,[6] progressive lipodystrophy,[7] and a very oily seborrhea of the face (Salbengesicht).[8]

Certain mental states, especially in children, are found so frequently after encephalitis that their presence should lead to careful inquiries as to a possible acute attack. Thus, Kirschbaum [9] reports four cases of encephalitis in children followed by a change in personality without mental deterioration. The first three patients showed asocial tendencies, in one case reach-

2. Achard, C., and Rouillard, J.: Bull. et mém. Soc. méd. d. hôp. de Paris **45**: 130 (Feb. 11) 1921. Guillain, G.; Jacquet, P., and Lechelle, P.: Ibid., p. 74.

3. König, Otto: Ztschr. f. d. ges. Neurol. u. Psychiat. **75**: 221, 1922.
4. Globus, J. H., and Strauss, Israel: Subacute Epidemic (Lethargic) Encephalitis, Arch. Neurol. & Psychiat. **8**: 122 (Aug.) 1922.
5. Stiefler, G.: Monatsschr. f. Psychiat. u. Neurol., August, 1921. Bertolani, A.: Riv. sper. di freniti **45**, 1922. Barkman, A.: Acta med. Scandinav. **56**: 188 (March) 1922.
6. Sarbo, A.: Orvosi hetil. **65**, 1921.
7. Sarbo, A.: Orvosi hetil. **65**, 1921.
8. Stiefler, G.: Ztschr. f. d. ges. Neurol. u. Psychiat. **73**: 455, 1921.
9. Kirschbaum, Max: Ztschr. f. d. ges. Neurol. u. Psychiat. **73**: 599, 1921.

ing the degree of actual "moral insanity." The fourth patient presented a hypomanic state, boiling over with activity and happiness. The author is at a loss to explain the relationship between a more or less focal brain disease and the psychic transformation. It is striking that similar conditions have not been reported in adults in whom we find nervousness, depression, disinclination for work, exhaustibility and deterioration, but not this kind of character change.

Psychic sequels in six children are described by Bonhoeffer.[10] In the acute stage there had not been parkinsonian symptoms but delirium, disordered sleep, ocular symptoms and, in some cases, panting respiration. After the recession of the acute phase, the children became talkative, bold, obtrusive, without respect and inhibition and unsocial, with occasional emotional outbreaks. There was no hereditary psychopathic predisposition, so the encephalitis itself must be considered the sole cause. No such transformation of the personality was observed in adults, who merely displayed diminution of activity and volition.

Staehelin,[11] an assistant in Blueler's clinic, Zurich, has contributed a long article on the psychopathology of the postencephalitic states. A peculiar case of postencephalitic mental disorder in a girl, aged 13 years, observed at the Psychopathic Hospital, was recently presented to the Chicago Neurological Society by Neymann.[12] A normal child prior to the attack of encephalitis a year and a half before, she now was an "inveterate liar, extremely incorrigible, quarrelsome, bit the other children, cuffed them, knocked them down and finally put pins in the tips of her shoes and kicked them." [13]

Kauders [14] describes "moria-like and defective states" as occasional sequels. From the large material of Wagner von Jauregg's clinic in Vienna, he has selected six cases, all in persons from 5 to 17 years of age. Some of these patients showed a typical moria-like mental state with desultory thinking, silly cheerfulness, with fondness for making puns (witzelsucht), a condition frequently described in connection also with frontal lobe tumors. In some cases motor restlessness was marked, the picture suggesting the old term "hyperkinetic motility psychosis," coined long ago by Wernicke. Mannerisms and stereotyped movements were also present in these postencephalitic cases. Finally, in several cases a neurasthenic or psychopathic state gradually developed, with interrelation of motor disturbances and psychic peculiarities. Characteristic of the whole group is the organic, neurologic substratum of the psychic manifestation.

Also in adults, conduct disorders indicative of lowering of ethical standards may call attention to preceding encephalitis. One day two women came to my office and related how the husband of one of them had stood up masturbating in front of an open window in full view of the other woman and her daughter across the alley. This had been repeated on several occasions. The wife added that her husband had changed since he had the influenza, had become indolent and shiftless, and had lost his desire for normal sexual gratification. I sent for the man, and he presented the typical postencephalitic parkinsonian syndrome. He did not have a real psychosis; he was rather anemic, and much discouraged. He rapidly improved when given encouragement, and gave up both exhibitionism and masturbation.

I have dwelt so long on these psychic sequels because I believe they are, as yet, little understood in this community. There are not only postencephalitic pseudoparkinsonians, but also postencephalitic pseudoschizophrenics, even pseudomorons. The possibility of preceding encephalitis should always be looked into. Another advantage to be gained by careful catamneses is the possible recognition of abortive types of the acute illness. These are probably very common, but so far we have lacked criteria for their recognition.

DIAGNOSIS OF THE ACUTE STAGE

The condition of the spinal fluid has been described at length by Kraus and Pardee,[15] and more recently by Eskuchen.[16] The latter summarizes the available data, stating that there are two spinal fluid syndromes which may be considered fairly characteristic:

A. Pleocytosis. Globulin increase. "Luetic" gold curve. Hyperglycorhachis (sugar increase).

B. Cell-globulin dissociation (high cell count in proportion to the amount of globulin.) "Luetic" gold curve. Hyperglycorhachis.

In children, tuberculous meningitis offers great diagnostic difficulty, but in this disease the sugar content is usually diminished, the gold reaction occurs in the higher dilutions, and the cell count is usually higher.

Botulism may closely resemble epidemic encephalitis both clinically and postmortem. Thus, Geiger [17] relates a case from San Francisco in which a clinical and anatomic diagnosis of encephalitis stood unchallenged until *Bacillus botulinus* was isolated from the medulla oblongata.

Tumors of the third ventricle and basal ganglions may be clinically identical with encephalitis, running a febrile course, with rigidity, characteristic tremors, etc. I have reported such a case.[18] The same is true of localized basal meningitis with extension to the third and fourth ventricles.[19]

In the early stages I have had difficulty in excluding such diseases as typhoid fever, acute miliary tuberculosis and chorea; and in cases of slow onset with little fever, the differentiation from catatonic dementia praecox, hysteria, and episodes of excitement in the feebleminded. In one child, even muscular dystrophy has been troublesome. Cases with predominating spinal cord involvement seem to exist and are most difficult, as are those complicated by preexisting chronic nervous diseases, such as cerebrospinal syphilis and multiple sclerosis. Altogether, no disease makes greater demands on the all-around knowledge of the diagnostician than epidemic encephalitis.

10. Bonhoeffer, K.: Klin. Wchnschr., July 15, 1922.
11. Staehelin, J. E.: Ztschr. f. d. ges. Neurol. u. Psychiat. **77**: 171 (June 20) 1922.
12. Neymann, C. A.: Postencephalitic Mental Disorder, Arch. Neurol. & Psychiat. **8**: 582 (Nov.) 1922.
13. Important contributions by American observers on this condition have been made by Richman, L. B.: Bull. Johns Hopkins Hosp. **33**: 372 (Oct.) 1922. Leahy, S. R., and Sands, I. J.: Mental Disorders in Children Following Epidemic Encephalitis, J. A. M. A. **78**: 373 (Feb. 3) 1921.
14. Kauders, Otto: Ztschr. f. d. ges. Neurol. u. Psychiat. **74**: 431 (Feb. 16) 1922.
15. Kraus, W. M., and Pardee, I. H.: Serology of Spinal Fluid and Blood in Encephalitis, Arch. Neurol. & Psychiat. **5**: 710 (June) 1921.
16. Eskuchen, Karl: Ztschr. f. d. ges. Neurol. u. Psychiat. **76**: 568, 1922.
17. Geiger, J. C.: Pub. Health Rep. **36**: 1663 (July 22) 1921.
18. Bassoe, Peter: A Case of Third Ventricle Tumor Mistaken for Lethargic Encephalitis, Arch. Neurol. & Psychiat. **4**: 118 (July) 1920.
19. Locper, M., and Forestier, J.: Progrès méd. **36**: 111 (March 12) 1921.

Ophthalmology in Ecuador.—As late as the seventies, ophthalmology was unknown in Ecuador. It was introduced by Dr. E. Gairaud of the Montpellier (France) school, who was appointed dean of the Quito Medical School in 1873. The first cataract extraction was made by Dr. Antonio Falconi in 1878

ULCER OF THE STOMACH AND DUODENUM

DIAGNOSIS AND TREATMENT FROM THE ROENTGENOLOGIC STANDPOINT

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The literature of twenty-five years ago discloses the fact that chronic ulcer was hardly recognized by pathologists of the time, and the clinical picture of the disease was entirely overlooked. The presence of ulcer was usually suspected through the occurrence of hemorrhage, perforation or pyloric stenosis. We owe our knowledge of the pathology and symptomatology of chronic ulcer primarily to surgical exploration, but roentgen-ray study of ulcer, in more recent years, has opened an entirely new avenue of approach. The accurate location of the site and determination of the kind of lesion, or a definite negative diagnosis, can now be attended with only a small percentage of error; and the employment of this method of study in gastrointestinal cases, in general, makes possible the accurate diagnosis of a variety of ulcer-simulating lesions. Roentgenology, used more and more as a routine, is destined to have a far-reaching effect on our conceptions of the symptomatology of the disease, the prognosis of different types and sites of ulcer, and the actual results of treatment which may be expected for each particular lesion. The data on ulcer which emanate from surgical clinics are misleading, because the surgeon deals so largely with cases of long duration, unrelieved disability or established accidents of the lesion.

In the course of years, the opportunity has arisen to examine, from the roentgen-ray and clinical standpoint, a considerable number of patients with ulcers of varying kinds and duration. Many of these patients have remained under immediate or remote observation for months or years; and, as a result, our opinions on various phases of the ulcer problem have been decidedly influenced, and our handling of patients considerably modified.

RELATIVE DEPENDABILITY OF ROENTGEN-RAY AND SYMPTOM DIAGNOSIS OF ULCER

The one important symptom in the diagnosis of ulcer is localized epigastric pain, distress or gas, which comes on once, twice or three times daily, one-half hour to five hours after food ingestion. The diagnosis of ulcer is made without any other symptom or physical sign, especially if there are also definite food ease and periods of remission. The exceptions to this rule are so few that I am suspicious of ulcer in spite of negative findings. It is surprising that ulcer is still so generally overlooked, from the clinical standpoint, in view of all that has been said in recent years about this pathognomonic symptom. I always feel that, in spite of the demonstration of other lesions, at least a superficial ulcer may be present. The roentgen-ray evidence of ulcer may fail because of incomplete study or the overlooking of definite evidence; but nevertheless there is a small proportion of cases of ulcer, possibly 5 per cent., in which the roentgen-ray diagnosis is unsuccessful, owing to the peculiar character or position of the lesion.

In the absence of this pathognomonic symptom, the diagnosis of ulcer is absolutely uncertain except by a roentgen-ray study. We have no idea as to the number of these cases because they have so largely passed unrecognized. Certainly, we see occasional perforations of ulcer and hemorrhage from ulcer, with not the slightest previous history of pain, and we see patients who continue to bleed more or less for years without suffering any suggestion of pain.

Gastric ulcers give rise at times to an atypical distress, persistent nausea and vomiting, belching or sour eructations, and the only hope of a definite diagnosis is serial roentgenology or exploration. It is in these atypical cases that the question may well arise as to whether the roentgen-ray series enables us to differentiate sharply between an active and a healed lesion. As this question, even at operation, is sometimes difficult to answer, it is obvious that the problem is troublesome, especially in clinically doubtful cases and in those with persistence of symptoms after medical and surgical therapy. I think we must agree that the complete healing of ulcer is attended with the absorption of induration, to a degree that permits the normal passage of the peristaltic wave over the affected area. This occurs with striking rapidity when a second exploration of the stomach is made only a few months after a successful gastro-enterostomy, or when a serial roentgenographic examination is made. Penetrations or craters are seen to have filled, in some cases, even a few days after the inauguration of successful treatment.

Spasm of the musculature opposite the point of the ulcer, whether in the stomach or in the duodenum, strongly indicates the persistence of the lesion; and, when it disappears, we find that there are satisfactory end-results. The surgeon who sometimes sees white lines on the peritoneum, without underlying induration indicating the previous site of an ulcer, must remember that such a condition would not give rise to roentgenographic evidence of ulcer, as it does not affect the musculature at that point.

In the differential diagnosis between ulcer and cancer, we are seldom confronted with serious difficulties, because cancer is almost always an insidious lesion, free from symptoms during its early stages, and, by the time the case comes under observation, the lesion is well advanced and, in the majority of cases, is characteristic in appearance. I doubt that it is possible, on roentgen-ray examinations, to make an absolute differentiation between very early cancer and ulcer except in a lesion which surrounds the pylorus, and here the small growth, no larger than an English walnut, presents a characteristic roentgenographic appearance.

PROGNOSIS OF ULCERS FROM THE ROENTGENOLOGIC STANDPOINT

The actual morbidity and mortality of chronic ulcer, or the frequency of serious complications, are obviously matters of the greatest interest in advising treatment. As we have no figures relating to the incidence of ulcer per thousand, we can be guided only by those conclusions which are based on the statistics obtained from the various avenues of discovery and treatment. Furthermore, we are not now concerned with ulcer in general, but with an ulcer that can be shown in a definite place, having definite characteristics; and therefore our prognosis must be individualized with increasing accuracy.

So far as ulcer in general is concerned, we have a greatly exaggerated idea as to its dangers. Passing usually as indigestion, relieved when symptoms are

active by a variety of simple remedies, or the ingestion of foods and fluids, ulcer is a much more common disease than has been imagined. This is especially true of duodenal ulcer, the incidence of which is very high. Those who see severe cases, or meet with resulting accidents, such as perforation or hemorrhage, are likely to have an entirely erroneous impression of the average gravity of the disease. I believe that the statistics which emanate from surgical clinics showing that from 15 to 25 per cent. of ulcers perforate or bleed severely are utterly fallacious. In the course of a long and busy career, a general practitioner will see few, if any, fatal outcomes from ulcer, although, perhaps unknowingly, he will probably have treated many cases.

Hemorrhage is an alarming phenomenon, but hemorrhage from ulcer is very rarely fatal. Certainly, the natural tendency of the chronic indurated ulcer of the duodenum is to remain in about the same condition for years. The old indurated ulcers, with much cap deformity, bleed severely or perforate in an extremely small minority of instances.

The percentage of stenosis from duodenal ulcer is too small seriously to force it on our consideration until it actually occurs, and, in a way, it would be fortunate if all duodenal ulcers ultimately caused stenosis, because gastro-enterostomy in these cases is nearly always perfect in its results. The general health is not appreciably affected by a duodenal ulcer. Year in and year out, we have seen many patients who have not been permanently affected by medical cures, and who have refused radical treatment, maintain their flesh and strength, suffering perhaps from a minor disability which requires annoying care in diet, in order to forestall or relieve exacerbations of symptoms.

Ulcers of the stomach are quite different from those of the duodenum in that their natural tendency is to increase in size of crater and induration. While these old ulcers rather rarely bleed severely or perforate, they frequently persist in giving rise to symptoms. The small ulcers which show penetration of the mucosa with little induration, ordinarily of comparatively recent onset, seem to be more dangerous so far as perforation or hemorrhage is concerned; but one can easily get an exaggerated idea of the danger of these ulcers from the roentgenographic appearance.

To what degree one may urge surgery for the removal of gastric ulcer, on the theory that cancer originates from ulcer, is extremely hard to decide. One cannot disregard the opinion of that group of pathologists and surgeons who believe this a frequent occurrence, although the evidence is not regarded as convincing by the majority of pathologists and clinicians. Certainly, the clinical picture of cancer, as we see it, is absolutely different from that of ulcer. Admitting a small percentage of such degeneration, it seems that the expected mortality from the routine excision of gastric ulcers would be much higher than the mortality arising from their degeneration into cancer if not excised, especially if one takes into consideration the fact that gastro-enterostomy will cure many gastric ulcers that are rebelious to medical treatment.

RESULTS OF MEDICAL AND SURGICAL TREATMENT OF ULCER FROM THE ROENTGEN-RAY STANDPOINT

Unfortunately, we do not know what produces peptic ulcers and makes for the stubborn persistence of such lesions. All treatments except excision are empiric, and how they affect ulcers is still questionable. The theory of infection seems extremely tenable; but, apparently, there are other factors that at least enter into the continuance of the lesion. While the removal of the tonsils and of local infections around the teeth has given rise in some recent cases to the most prompt and striking cures, the results in cases of long standing have proved disappointing.

Medical treatment gives prompt relief from symptoms in most duodenal ulcers and in some gastric ulcers. I see no advantage in the classic rest in bed ulcer cure, with all the expense and loss of nutrition it entails, except that the patient is thereby kept under better control. The prolonged individualized frequent feeding treatment as emphasized by Sippy gives equally good results if the patient is up and about and possibly attending to daily occupations. The length of treatment I regard as a most important point, measuring the period by months rather than by weeks. So far as we know, medical treatment merely establishes favorable conditions for the spontaneous healing of the lesion, a phenomenon which probably occurs much more frequently without treatment than is generally appreciated.

While duodenal ulcer symptoms are almost always well controlled by dietetic treatment, the lesion is infrequently cured thereby. In the follow-up roentgen-ray study, evidence of ulcer persists, and eventually the symptoms return. It is amazing how many times some of these duodenal ulcer cases have been pronounced cured, and, according to statistics, how small a percentage of failures follow medical treatment. However, the danger to life, particularly in old cases, is negligible, and the question arises whether we are justified in urging surgical intervention for what is usually a minor disability. The younger the patient, the greater the excuse for surgery. To operate on a patient of 60 or more, when the symptoms of duodenal ulcer can be controlled satisfactorily by dietetic treatment, seems almost absurd. When dietetic restrictions are extremely irksome or incompatible with earning a livelihood, a frequent recurrence of the disability, in itself, amply justifies operation, even without an attempt at prolonged medical cure. The sociological condition of the patient may be the deciding factor.

The percentage of cases of gastric ulcer relieved by medical measures is not so great as in duodenal ulcer. There is, however, a fair percentage of actual cures of gastric ulcer by medical treatment, even when the lesion is old and much indurated. Surgery should be urged after a single period of dietetic treatment, if the disability is not relieved and the lesion shows a progressive tendency. Many will be confirmed in this opinion because of the possibility of cancerous degeneration of the gastric ulcer; a sequel, however, which is practically never seen in duodenal ulcer.

SUMMARY AND CONCLUSIONS

The frequency of peptic ulcer has been greatly underestimated, and the relative danger of the lesion greatly exaggerated, because only the more severe and complicated cases have come under observation or have been recognized through clinical study.

Until we know more definitely the cause of the lesion and the reasons for its stubborn persistence, we can hardly hope for a specific cure and a satisfactory routine for the handling of these cases.

Meanwhile, treatment must be individualized on the basis of the site and the character of the lesion as shown by roentgen-ray study; the subsequently demon-

strated change in the lesion; the amount of disability, and the presence of complications such as hemorrhage, perforation and stenosis. But, in addition to all these considerations, in reaching a decision as to a plan of treatment, we must give due regard to the life expectancy in the individual patient, and the economic necessity for absolute rather than temporary symptomatic cure, which is the frequent limit of medical therapy.

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CHILD HYGIENE AND THE PRIVATE PHYSICIAN *

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I do not believe that any one—physician or layman—is opposed to the basic aims of the child hygiene movement; that is, the lowering of the mortality rate for infants and children and the prevention of sickness. In its origin, the movement was largely medical, and was directed toward the study and prevention of specific diseases; as, for example, the intestinal diseases of infancy. In its development, the scope of the movement has become much broader, and is directed chiefly to the rearing and development of a healthy race of infants and children.

The methods so far employed may be grouped under three headings: (1) the use of specific means, as, for example, the crusade for pure milk or the use of toxin-antitoxin in diphtheria; (2) educational methods, including such diverse items as propaganda through the press, the holding of health exhibits, the teaching of health habits to groups of children in the schools and the visitation in the home by health workers, and (3) the direct supervision of the infant and child by the physician through clinics, or—a better term—welfare conferences. It is extremely difficult to estimate the relative value of the methods employed, as they are so largely interrelated, and it is much more important to raise the question as to whether the methods in use are the best or the ones capable of producing the greatest possible results.

The Infant Welfare Conference had its origin a few years ago in the establishment of summer clinics to care for infants with gastro-intestinal diseases. As an outgrowth of this, all the year round clinics were established in order to lessen the conditions which predisposed to the "summer diseases." As the work progressed, it was found that the essential need was not a clinic for sick infants but a clinic for well infants, a place where the babies could be watched and the mothers guided and instructed in their care. Thus, what started as a purely therapeutic or medical clinic gradually developed into a preventive medical conference. Many of the early clinics were established in connection with milk stations where pure and even free milk was distributed, a combination which we know today is wrong in principle, as the milk station exerts a bad psychologic effect on the nursing mother. The preschool clinic or conference had its origin in an attempt to save from waste much of the work of the infant conference, as experience showed that a large number of children developed physical defects between the time they left the supervision of the infant clinic and the time they entered school.

There are certain inherent basic defects in the welfare conference to which the infant or child is brought from time to time for examination by the physician and for advice and in which the physician's work is supplemented by the home visitation of the nurse or social worker. First, the welfare clinic must limit itself to the well child, and this is the rule of the well run conference. Experience has shown that, when the well child and the sick child mingle in the clinic, the greater part of the work and attention must be given to the sick child; and, as the essential purpose of the welfare clinic is prevention rather than correction or therapeutics, the presence of the sick child defeats the very purpose of the conference. Furthermore, the mingling of sick children and well children is contraindicated from the medical standpoint. The conference physician is working to prevent the development of diseases or conditions of which he has no personal or intimate knowledge, and thus, in many ways, he is groping in the dark. He cannot advise accurately or fully regarding the prevention of disease tendencies in the individual child unless he knows the reaction of the individual when sick. Every physician knows the interdependence of health and sickness, and the observation of the child when sick is in many instances the most important factor in determining what to do when the infant or child is well. All this is lost, in large extent, to the conference physician.

A second fault is the failure of the physician to see the child in its normal every day surroundings. There is a close and intimate relationship between the physical condition of the child and its environment. The attempt, for example, to do nutritional work without a personal knowledge of the child's home, his parents and his life will not meet with much success. To try to replace this personal touch with home visits by the nurse or social worker and to obtain a comprehensive picture from their written or personal reports is at best an unsatisfactory and incomplete substitute.

Another element of weakness lies in the constant change in the clinic personnel. The child loses not only in passing from one conference to another as he advances in age, as from the infant to the preschool period, but also from the constant change taking place in the staff. No matter how complete the written record, the personal knowledge of the infant or child must be picked up anew by each physician. Even more frequent are the changes in the nursing staff. This lack of continuity of supervision as the infant develops into the child becomes more marked the more intensive the work of the health center becomes, and it is a difficulty that we are finding of increasing perplexity in our work.

Lastly, the conference method has a decided limitation in the number of children reached, as only a small proportion are enrolled in a given district or community. Welfare clinics have been free as a rule and classed among the "charities," and most clinics have fixed regulations limiting the attendance to those children unable to pay for a physician's services. Yet those of us who have worked both in the free conference and in private work realize that there is just as much need of health work among the children of the middle and well-to-do classes of society.

The best results can be obtained only if there is direct and constant supervision of the child through infancy and childhood by one physician, who sees the child in sickness as well as in health, and who has an intimate and personal knowledge of its parents, its home life and daily environment, its play and companions. Without a full knowledge of all of these factors, the value of

* Read before the American Child Hygiene Association, Washington, D. C., Oct. 12, 1922.

direct supervision is limited and handicapped. Furthermore, this supervision must reach the children of all classes and must not be limited to the economically dependent. If my objections and conclusions are valid, there is but one logical deduction, and that is that the person in the ideal position to supervise the health and welfare of the infant and child is the private physician —the man in general practice.

If this is true, the question naturally arises, Why then is this work not done by the private physician? Why the necessity for the welfare clinic or conference? The answer is simple: Unfortunately, the vast majority of physicians in private practice are not qualified to supervise the development of the infant and child. Few recognize its importance; fewer still are interested; and, most important, even fewer have been trained to apply in general practice the methods which have met with such success in infant and child hygiene work. The last thing I have in mind in making this statement is an unpleasant or undeserved criticism of the practitioner of medicine. It is a simple statement of fact that is apparent to those interested in child hygiene work. One of the most frequent statements made to me by parents is to the effect that "Dr. ——, our physician, is fine when the children are sick, but he has no interest in them at other times." The mothers of today have been educated to ask for guidance in the bringing up of the infant and child, and the private physician has not been educated to give it. Twenty-five per cent. of the infants coming to the welfare clinics in St. Louis who are taking condensed milk food had been taken from the breast and put on condensed milk by physicians in private practice.

The fault or blame lies in the training and education of the private physician. In the past, and the same holds to a large extent at present, our medical students have been trained to think in terms of disease rather than of health, and our teaching, which has been almost entirely in hospitals or dispensaries, has been directed almost exclusively to the recognition and treatment of pathologic conditions. Such teaching as the student has received in hygiene or health has been of an abstract nature and not concretely applied to the individual. The lack of knowledge on the part of the private physician in regard to the hygiene and development of the infant and child is the fault of the physician's training, not of the physician. There must be a distinct change in the character of our pediatric teaching, and this change is already taking place in our better medical schools. For example, instead of spending hours over the classification and pathologic physiology of the nutritional diseases of infancy, the point that must be emphasized and driven home is the care and feeding of the normal infant: the prevention of disease must be stressed equally with the pathogenesis, diagnosis and treatment. When this is done, we shall have a group of men in our community interested in giving ideal supervision to the infant and child; but we cannot with reason expect this change to take place over night. As I have tried to point out, the methods themselves have been gradually evolving, and to ask or expect the entire group of busy practitioners of medicine suddenly to change their attitude is to ask and expect too much. Some of us are familiar with the difficulty as applied to many of the pediatricians themselves. If the principles and practice of child hygiene are as important as we believe them to be, the situation will automatically correct itself in time.

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Clinical Notes, Suggestions, and New Instruments

TETANUS WITHOUT EVIDENT PORTAL OF ENTRY

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E. W., a man, aged 27, with a negative history, had a root filling put in a tooth, Jan. 3, 1922. January 15, the neck became stiff, and he was unable to open his mouth. On the 16th, he began to have tonic and clonic spasms, involving all the muscles of the body, particularly the extremities and abdomen. Thirst increased, sweating became profuse, and there was great irritability. On the 19th, 11,000 units of tetanus antitoxin was given subcutaneously by a local physician. January 22, he was removed to the Park Avenue Clinical Hospital, Rochester, where a diagnosis of tetanus was made. The spinal canal was tapped, and he was given 4,000 units of tetanus antitoxin intraspinally, 11,000 intravenously and 20,000 subcutaneously. The filling was immediately taken from the dead tooth, which was extracted on the following day. He was given 200 c.c. of a 25 per cent. solution of magnesium sulphate subcutaneously, and morphin as necessary in one-fourth and one-half grain doses. January 25, 26 and 27, he was given tetanus antitoxin subcutaneously, 10,000 units each day. On the 24th, his tonic spasms had become less frequent, the muscles of the abdomen and the extremities began to relax, the jaw could be more widely opened, thirst was not so constant, and sweating was less profuse. From this time on, the patient made an uneventful recovery.

This case is reported to emphasize tetanus without an evident portal of entry, though the period of incubation points toward the filling of the tooth as an explanation of the manner in which infection entered the body. There was slow progress of the disease, influenced, doubtless, by the administration of 11,000 units of tetanus antitoxin subcutaneously on the 19th. Finally, it is necessary to view any patient who has stiffness of the jaw and tenseness of the abdomen, accompanied by sweating, even in the absence of a wound, as a victim of tetanus.

During the present year, one of us has had two more cases of tetanus; both following wounds, and treated in the general manner described above, and in both of which the patients recovered. Two recent articles on tetanus should be kept in mind: that of Park and Nicoll[1] and that of Meltzer[2] of the Rockefeller Institute, in which he calls attention to the inhibitory action on nerves and muscles of magnesium sulphate when used subcutaneously. Here, although we see tetanus rarely, one of us having seen but twenty cases in recent years, we keep constantly on hand, as recommended by Meltzer, a 25 per cent. solution of chemically pure magnesium sulphate for use in tetanus.

1. Park, W. H., and Nicoll, Matthias, Jr.: Experiments on the Curative Value of the Intraspinal Administration of Tetanus Antitoxin, J. A. M. A. **63**: 235 (July 18) 1914.
2. Meltzer, S. J.: Inhibitory Properties of Magnesium Sulphate and Their Therapeutic Application in Tetanus, J. A. M. A. **66**: 931 (March 25) 1916.

Accidental Deaths in New York City.—During 1921, as the result of accidents, 3,483 persons died in New York City. About 75 per cent. of all deaths (2,496) from accidents were of males, as compared with 987 of females. Persons at the extremes of life suffered most heavily from accidents—in other words, those least able to take care of themselves. The most important cause of accidental death, numerically, was the automobile. During 1921, 849 persons were killed as the result of automobile accidents. This is equivalent to a ratio of almost 15 per hundred thousand, and is a net increase of one per hundred thousand since 1919. Males suffered a death rate of almost three times the female. The heaviest mortality was between the ages of 5 to 14 years, the years during which children use the streets most for play, and when they are least careful.—*School Health News*, November, 1922.

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SATURDAY, DECEMBER 30, 1922

ANAEROBIC OXIDATION IN THE BODY

Since the chief end-products of metabolism are more highly oxidized compounds than the substances that serve as foods, it is customary to regard the life processes as primarily oxidative in nature. Oxygen is quite as important as is food, if it is not actually even more essential to most organisms. Despite this well accepted fact, the mechanisms by which oxygen does its life-supporting work are far from being well understood. Indeed, it has been one of the long standing puzzles of science how certain types of oxidative reactions that can be carried out with difficulty at best in the laboratory, and there often only at temperatures incompatible with life, proceed so readily in the tissues or fluids of the living organism. Whereas there are some substances that are easily oxidized by the oxygen of the air, others (including the foodstuffs) require the oxygen to be made "active," as it has been fancifully stated. In such "activations," enzymes have long been conceived to play a significant part.

Some time ago, Bach [1] suggested the existence of what he termed "hydrolytic oxidative-reducing reactions" to explain certain phenomena of oxidation that proceed without the presence of free oxygen. An illustration is afforded by the Schardinger reaction in milk.[2] If methylene blue and an aldehyd are added to fresh specimens of this fluid, the dye becomes reduced and the aldehyd oxidized. The theory assumes that, through the agency of an enzyme, water—HOH—is disintegrated to yield nascent hydrogen. The methylene blue serves as a hydrogen acceptor; the aldehyd, as the oxygen acceptor. Thus, reduction and oxidation occur simultaneously without the advent of free oxygen. Conditions are thus established for what may be termed anaerobic oxidation.

Morgan, Stewart and Hopkins [3] of the Biochemical Laboratory at the University of Cambridge, England, have shown the possibility of the occurrence of important biochemical reactions in this way. Certain animal tissues, as well as milk, are able to bring about the oxidation of xanthin and hypoxanthin to uric acid under strictly anaerobic conditions, if a "hydrogen acceptor," such as methylene blue, is present. The English biochemists discuss evidence favoring the probability that the catalytic system responsible for the anaerobic oxidation is not distinct from that which controls oxidation in the presence of free oxygen.

In this connection, it should be noted that Hopkins [4] has made the remarkable discovery of the existence, in tissues, of a dipeptid—glutathione—of which the constituent amino-acids are glutaminic acid and cystein, and in which the constituent sulphur-containing groups are capable of functioning in an oxidation-reduction system. Substances permitting such reversible processes thus may actually occur in the body. At suitable hydrogen ion concentrations, reduced glutathione is oxidized by molecular oxygen, and under similar conditions it freely reduces methylene blue. On the other hand, in the tissues there are factors present which promptly reduce the oxidized product whenever its concentration is raised above an equilibrium value.

In such ways, transfer of both oxygen and hydrogen becomes possible in the organism. Instead of being transferred to the experimental methylene blue, however, hydrogen becomes transferred to molecular oxygen. In both anaerobic and aerobic oxidations, the dipeptid accelerates transport and acts as a "carrier." In this sense it is a catalyst. Hopkins and Dixon [5] have found, further, that coexisting in living tissues with the specialized enzymic mechanisms is a thermostable mechanism for oxidations and reductions. Materials in some close association with structural elements are oxidized, anaerobically or aerobically, with the coagency of the sulphur group in glutathione. The problem of tissue oxidation is thus being subjected to analysis from new points of view.

CONGENITAL PORPHYRINURIA

The discovery of chemical anomalies in the body almost invariably excites attention because of the comparative rarity of the cases. There is an almost uncanny mysteriousness in the failure of a person, year after year, to burn up the amino-acid cystin, for example, which is liberated daily in equal measure by digestion in innumerable other persons and yet disappears completely in their metabolic processes, instead of being excreted unchanged as it is in the cystinuric person. Thus, cystinuria, pentosuria and alkaptonuria are a never-failing source of interest for the student of metabolism—an interest which has been greatly

1. Bach, A.: Zur Kenntnis der Reduktionsfermente, I, Biochem. Ztschr. **31**: 443, 1911; **38**: 154, 1912.
2. Schardinger, F.: Ztschr. f. Untersuch. d. Nahrungs- u. Genussmittel **5**: 1113, 1902.
3. Morgan, E. J.; Stewart, C. P., and Hopkins, F. G.: Anaerobic and Aerobic Oxidation of Xanthin and Hypoxanthin by Tissues and by Milk, Proc. Roy. Soc. London, Ser. B **94**: 109 (Sept.) 1922.
4. Hopkins, F. G.: Biochem. J. **15**: 286, 1921.
5. Hopkins, F. G., and Dixon, M.: On Glutathione, II, A Thermostable Oxidation-Reduction System, J. Biol. Chem. **54**: 527 (Nov.) 1922.

extended by the added discovery that such metabolic anomalies are frequently congenital in character. There are now on record numerous instances of these inherited chemical defects which persist through more than one generation, and seemingly are transmitted in accord with the principles of mendelian inheritance.

Another perversion of metabolism, resulting in the excretion of derivatives of the blood pigment in the urine and sometimes also in the feces, has often been observed in certain types of intoxication, notably with sulphonmethane, sulphonethylmethane and quinin. The result, hematoporphyrinuria, has been regarded as almost diagnostic of such forms of acute poisoning. Recently, however, the porphyrins have come even more conspicuously to the attention of the medical profession, since it has been shown that their presence in the body may sensitize it to light. Sufficient doses of hematoporphyrin have sensitized mice so that they become narcotized and die in a few minutes after exposure to intense light, a true "light stroke."[1] Furthermore, injection of hematoporphyrin into the circulation of a human subject has resulted in so sensitizing him to light that exposure to the sun caused severe skin reactions during a period of weeks, and exposure to the Finsen rays produced severe ulceration.[2]

For some time, cases of porphyrinuria, congenital in origin rather than following some intoxication with a drug, also have been on record in medical literature. The credit of having recognized the possibility that they represent a rare inborn error of metabolism belongs to Günther.[3] It advertises itself primarily by the distinctly abnormal color of the urine. The known cases do not exceed fifteen in number; and as in the instances of other comparable chemical anomalies, the incidence has been preponderantly in the male sex. The latest record is by Mackey and Garrod,[4] in whose case the evidence of congenital onset is more complete than in any other recorded. In the patient, a boy, porphyrins were present in both the urine and the feces in considerable quantity. As in previous cases,[5] he presented an association of porphyrinuria with extreme sensitiveness of the superficial tissues to light, as shown by annual eruptions of hydroa aestivale on the exposed surfaces of the skin. A unique feature was the deep pink coloration of the milk teeth; in fact, the porphyrin pigment seems also to have deposited in the skeletal bones.

With respect to the possible genesis of the persistent porphyrinuria, it is worthy of note that there is no excessive blood destruction, if one may judge by the comparative normality of the blood count. Mackey and Garrod have pointed out that, whereas in cases of the anomaly alkaptonuria the characteristic homogentisic acid, as evidenced by the staining power of the urine, is not present until after food has entered the alimentary canal, so that the abnormal metabolic product has an exogenous source, porphyrinuria appears not to be influenced by diet. They believe rather that the porphyrin is an intermediate product between blood pigment and bile pigment.

The description of these unusual facts, reminding one of the occasional records of the deposition of cystin in the tissues in rare cases of cystinuria, should stimulate clinicians to be on the lookout for further instances of disordered pigment metabolism. Perhaps they will help to explain dermatologic lesions for which a satisfactory causation is not easily ascertained.

1. Wells, H. G.: Chemical Pathology, Philadelphia, W. B. Saunders Company, 1920, p. 485.
2. Meyer-Betz: Deutsch. Arch. f. klin. Med. **112**: 476, 1913.
3. Günther, Hans: Deutsch. Arch. f. klin. Med. **103**: 89, 1911-1912.
4. Mackey, L., and Garrod, A. E.: On Congenital Porphyrinuria, Associated with Hydroa Aestivale and Pink Teeth, Quart. J. Med. **15**: 319 (July) 1922.
5. The Porphyrins in Pathology, editorial, J. A. M. A. **60**: 998 (March 29) 1913.

ASPECTS OF THE TUBERCULOSIS PROBLEM

There are many persons still living who can recall the discovery of the micro-organism responsible for tuberculosis, the disease described as "the commonest, most fatal and, perhaps, the saddest of all those which oppress mankind." With growing knowledge of its etiology and manifestations has come greater mastery over its ravages. The day is not far past when a diagnosis of consumption—a malady that was killing one seventh of all people born under civilization—was equivalent to signing a death warrant. Nevertheless, the problem of meeting this enemy of mankind has been faced with resolution and with a reasonable measure of success. Sunshine, food and fresh air have had their advocates in this connection. The outcome of the various proposals, whether they concern treatment in the home or in the sanatorium, has been decidedly encouraging; yet, despite the seemingly favorable progress, there is no unanimity of opinion with regard to some of the most fundamental factors in the tuberculosis problem. Almost from year to year there has been a succession of different points of view, attesting to the fact that there is much still to be learned, and indicating the danger of basing propaganda on debatable premises.

An illustration is afforded by the changing views with respect to the mode of infection in tuberculosis. As Landis[1] has recently remarked, for some years the trend of opinion was strongly in favor of the alimentary mode of infection, and many experimental studies were carried out which seemed to support this belief. Within the last few years, however, the pendulum has swung back in favor of the inhalation theory. One is probably safe in saying that infection through the intestinal tract, while accountable for some cases, is of minor importance as the portal of entry.

The occurrence of primary intestinal tuberculosis is, of course, well recognized, particularly in children. Their intestinal mucous membrane seems to be especially permeable, and the infection in them appears to

1. Landis, H. R. M.: Tuberculosis, the Oxford Medicine **5**: 263.

be due to the bovine bacillus, presumably derived from milk, which has entered through the gastro-intestinal tract. On the other hand, there are abundant statistics to indicate that pulmonary tuberculosis is almost always caused by the human type of tubercle bacillus. This fact has an important bearing on the debated question as to whether the tuberculosis of adult life is invariably traceable to infection in infancy. In his Gross lecture before the Pathological Society of Philadelphia, Opie [2] of St. Louis pointed out that there is no universal agreement concerning the portal of entry of micro-organisms which produce pulmonary tuberculosis. Von Behring, as is well known, has maintained that phthisis is acquired in early infancy. Opie challenged this view. He admits that a small number of instances of phthisis acquired in childhood pursue an unusually chronic course and reach a fatal termination in adult life after the lapse of many years. But Opie asserts that von Behring's conception of tuberculosis acquired in early infancy appears to be disproved by the severity and almost invariably fatal course of tuberculosis acquired during the first year of life. A positive tuberculin reaction at this period is evidence of progressive tuberculosis, and suggests a grave prognosis.

There is excellent experimental evidence in support of the conclusion that various animals are far more susceptible to tubercle bacilli received through the air passages than to those ingested with the food. Opie finds no reason for believing that the results of the experiments are not applicable to human beings. Adults, he remarks, enjoy a relative immunity from tuberculosis because they are already infected. This immunity is only relative, and can be overcome by reinfection with tubercle bacilli in considerable amount, or by conditions, such as malnutrition, which depress the resistance of the individual. Tuberculosis of the lungs of adults, that is, phthisis, is caused by tubercle bacilli which reach the lung by way of the air passages, and measures adapted to prevent the dissemination of the micro-organism tend to limit the occurrence of the disease.

It is evident, accordingly, that the problem of prophylaxis hinges in no small measure on the theory of the pathway of infection. Despite the persistent uncertainty about the theory of phthisiogenesis, the importance of which should not be underrated, it is gradually becoming possible to express the results of the modern treatment of tuberculosis in tangible statistics. A recent compilation [3] of what has been accomplished at the Mount McGregor Sanatorium shows in a surprising way the outcome of a six-year attempt to rehabilitate tuberculous employees. Out of the 896 patients who were discharged from the beginning up to Dec. 31, 1920, and on whom a report was available as of Dec. 31, 1921, 719, or 80 per cent., were known to be at work; ninety, or 10 per cent., were unable to work, and eighty-seven, or 10 per cent., were dead. As might be expected, such data will vary with the condition of the patients on admission, a factor with which the ability to keep at work after discharge varies directly. The figures cited are not presented here as something exceptional, but rather to reemphasize the degree of success which the management of the tuberculous is meeting at the present day.

2. Opie, E. L.: Phthisiogenesis and Latent Tuberculous Infection, Am. Rev. Tuberc. **6**: 525 (Sept.) 1922.

3. Hawk, H. J.; Dublin, L. I., and Knudsen, I. A.: The After-History of 953 Tuberculous Patients Discharged from the Metropolitan Life Sanatorium from 1914 to 1920, Am. Rev. Tuberc. **6**: 707 (Oct.) 1922.

THE ALLEGED RELATION BETWEEN ALKALOSIS AND TETANY

The trend of the normal processes of metabolism is to produce acid substances, so that the problem of neutrality regulation involves, above all, effective elimination of acids. In acidosis, this capacity may become jeopardized. Owing largely to the writings of D. Wright Wilson and his co-workers,[1] the view has gained ground that at times there may arise a condition designated as alkalosis, in which the blood and consequently other tissue fluids attain an unduly alkaline condition. There is here an implication, at least, of an increase in the hydroxyl ions of the blood as an expression of the abnormal variation in the acid-base balance of the circulating medium. It has further been taught that at such a juncture there is a hyperexcitability of the neuromuscular mechanisms of the body, which may frequently be demonstrated by the lowered threshold of electric stimulation, and may even result in manifest tetany. Wilson found that injections of acid relieve the symptoms of the tetany attending removal of the parathyroid glands, and concluded that the alkalosis which he believed to exist was overcome by the acid. Furthermore, attention was directed to the occurrence of tetany after intravenous administration of large doses of alkali, notably soda solutions. Cases of gastric tetany in which pyloric obstruction is attended by loss of acid gastric juice through vomiting, or in which the acid thus secreted cannot enter the intestine and be returned to the circulation, have been put into the same category on the hypothesis that a surplus of base may remain in the blood.

Greenwald [2] of the Harriman Research Laboratory attached to Roosevelt Hospital, New York, has vigorously attacked the theory that alkalosis is the cause of tetany in any of the illustrative instances just mentioned. He cites the evidence offered by several investigators [3] to show that in fact there is no change either

1. Wilson, D. W.; Stearns, T., and Janney, J. H., Jr.: The Effect of Acid Administration on Parathyroid Tetany, J. Biol. Chem. **21**: 169, 1915. Wilson, D. W.; Stearns, T., and Thurlow, M. deG.: The Acid-Base Equilibria in the Blood After Parathyroidectomy, ibid. **23**: 89, 1915. Wilson, D. W.; Stearns, T., and Janney, J. H., Jr.: The Excretion of Acids and Ammonia After Parathyroidectomy, J. Biol. Chem. **23**: 123, 1915.

2. Greenwald, I.: The Supposed Relation Between Alkalosis and Tetany, J. Biol. Chem. **54**: 285 (Oct.) 1922.

3. Hastings, A. B., and Murray, H. A., Jr.: J. Biol. Chem. **46**: 233 (March) 1921. Underhill, F. P., and Nellans, C. T.: J. Biol. Chem. **48**: 557 (Oct.) 1921.

in alkalinity or in carbon dioxid-combining power after parathyroidectomy. Even after administration of large doses of sodium bicarbonate with consequent tetany, marked changes in the blood have rarely, if ever, been demonstrated. The retention of carbon dioxid becomes so large that the reaction is changed only slightly. According to Greenwald, the tetany, instead of being due to alkalosis, is attributable in such cases to the high concentration of sodium salts. When convulsions appear after the injection of sodium carbonate or bicarbonate, the concentration of sodium in the plasma is the same as when convulsions appear after the injection of sodium chlorid or sulphate. All sodium salts injected in large excess are toxic and, apparently, several of them are about equally toxic. In each case, there is produced a sudden and marked disturbance of the relation between sodium ions and other cations. Osmotic pressure plays a part, and the nature of the anion is not without significance. The toxic action, according to Greenwald, may depend on the ability of the sodium ion to penetrate the cell and thus upset the ionic equilibrium therein, or it may depend on its being unable to penetrate while combined with an anion that does, and in that manner damaging the cell by virtue of the electrical disturbance thus produced at the surface. But whatever the precise mechanism may be, he adds, there seems to be little doubt that the convulsions following the injection of sodium carbonate are due to what Greenwald [4] has called "sodium poisoning," a disturbance, attributable to excess of sodium ion, of the normal relations between this and other cations.

These newer criticisms of the widely accepted alkalosis theory of tetany aver that such convulsions are not due to any single cause. Any one of a multitude of disturbances in the equilibrium within certain tissues may be responsible. Convulsions are to be regarded as a sign of approaching or partial disintegration of the neuromuscular apparatus. The defect may occur in any one of several structures, and may be due to any one of many causes, according to Greenwald's interpretation. At any rate, the subject now invites further investigation; and it is of paramount importance in medicine where the problem of rational therapy of tetany is concerned.

4. Greenwald, I.: J. Pharmacol. & Exper. Therap. **11**: 281 (May) 1918.

Ten Years' Work for Children.—Ten years' progress in public provision for the care of children is summarized by Grace Abbott, chief of the Federal Children's Bureau, in the tenth annual report of the chief of the Secretary of Labor, made public today. Since 1912, when the children's bureau was established, the number of states having special divisions dealing with child health has increased from one to forty-six; the number providing mothers' pensions has increased from two to forty; more than half the states have created commissions to make comprehensive inquiries with a view to bringing their child welfare legislation and administration up to standard, and a similar number have organized state bureaus or divisions dealing especially with dependent and delinquent children.

Current Comment

THE BACTERIOLOGY OF THE DUODENUM

The enormous multiplication of bacteria which goes on at times within the intestine, both in health and in disease, tends to obscure the fact that this luxuriance of microbial life is by no means equally existent in all parts of the alimentary tract. The flora of the healthy stomach consists almost exclusively of organisms swallowed. The bactericidal effect of the gastric juice has long been recognized; and the significance of the potency of this secretion in inhibiting the development of the myriads of micro-organisms that find their way into ingested foods deserves emphasis as a most important aspect of gastric function. Accordingly, the duodenum ordinarily receives relatively few living bacteria from the healthy stomach. MacNeal [1] has pointed out that, in conformity with the available scientific evidence, the secretions of the liver, the pancreas and the duodenal wall are very free from bacteria, and tend to flush out the duodenum. His investigations with Chace [2] have indicated that in health the duodenal portion of the intestine is quite free from living bacteria in the intervals when food is absent, and that it contains relatively few bacteria during digestion. Among the living micro-organisms most frequently encountered in the duodenum are gram-positive cocci. *Bacillus coli* is uncommon there. These interesting and essential findings seem to have been rediscovered in Minkowski's clinic at Breslau by Gorke,[3] who reports that the duodenal secretion of healthy persons is virtually sterile. He, too, refers to the dependence of the duodenal flora on the chemical and motor functions of the stomach. Only when these are depressed do the bacteria gain a considerable foothold immediately beyond the pylorus. These are facts of foremost importance in relation to possible enterogenous infections of the biliary tract, pathologic processes in which the colon bacillus is the microbial offender usually concerned.

SIMULATION OF CARCINOMA BY TRAUMATIC FAT NECROSIS OF BREAST

It is an established fact that fat necrosis may occur anywhere in the body where adipose tissue abounds; but, curiously enough, it has been overlooked that it may occur in the corpulent female breast as a result of trauma, and that the clinical manifestations may simulate closely those of carcinoma. It has fallen to the lot of Lee and Adair [4] to direct attention to this condition by giving a clear description of the clinical, gross and microscopic findings in five cases of their own, and by calling attention to two other cases verbally reported to them by Bloodgood. Ewing of New York has worked out the pathologic anatomy of the specimens. As it

1. MacNeal, W. J.: Marshall's Microbiology, Philadelphia, P. Blakiston's Son & Co., 1921, p. 596.
2. MacNeal, W. J., and Chace, A. F.: A Contribution to the Bacteriology of the Duodenum, Arch. Int. Med. **12**: 178 (Aug.) 1913.
3. Gorke, H.: Ueber die Bakteriologie des Duodenalsaftes, Mitt. a. d. Grenzgeb. d. Med. u. Chir. **35**: 279, 1922.
4. Lee, B. J., and Adair, F. E.: Traumatic Fat Necrosis of the Female Breast and Its Differentiation from Carcinoma, Surg., Gynec. & Obst. **34**: 521 (April) 1922; Traumatic Fat Necrosis of the Female Breast and Its Differentiation from Carcinoma, Ann. Surg. **72**: 188 (Aug.) 1920.

concerns an unrecognized entity, the details may be of interest. The age of the patients varied from 36 to 54 years, and the weight from 152 to 211 pounds (69 to 96 kg.); there was a history of trauma, in all cases, in the locality where the tumor developed from three months to ten years later: twice a blow on the breast, and in three, hypodermoclysis. Two patients suffered pain; in all there was a hard mass; in one, retraction of the nipple; in four, skin fixation, and in two, deep attachment. In one, the axillary nodes, not palpable clinically, were found at operation to be enlarged, and in two there was a history of hemorrhages. The duration of growth was from one to ten months, and the preoperative diagnosis was carcinoma in two cases, and benign tumor, fibro-adenoma and fat necrosis each in one case. The altered areas varied from 2 to 5 cm. in their greatest dimensions; in four cases, the margins were irregular; in two there was partial encapsulation, and in three, cysts with fluid contents. There were no chalky streaks or points in any of the specimens, and the color of the affected tissue, hardly of the firmness of carcinoma in any case, was opaque, light yellow in most places, and in some, creamy to brownish yellow. In all the specimens, the microscope revealed areas of necrotic fat tissue, and in four, newly formed connective tissue with scattered giant cells in places; in three cases, collections of lymphocytes had gathered in the changed fat tissue. A laminated, hyaline connective tissue wall was present in one specimen, and another presented a cyst lined with endothelial cells, while three contained cysts with an amorphous granular material. In no case was carcinoma present. The authors believe that the condition they describe is a distinct clinical entity which resembles carcinoma more than anything else. A history of trauma to the breast with subsequent swelling at the site of injury, unassociated with pain or firmness of the axillary nodes, they think, should suggest the possibility of traumatic fat necrosis.

MALNUTRITION IN INFANTS, AND ALLERGY TO FOOD PROTEINS

The occurrence of various types of idiosyncrasy to special foods as well as to other heretofore obscure clinical manifestations of disease has been interpreted from time to time as the outcome of anaphylactic reactions or some analogous form of sensitization to foreign proteins in the body. The justification for such an hypothesis is found, among other evidences, in the experimentally demonstrable results of inoculation with such products. There is apparently little difference in the outcome whether the antigenic protein is administered subcutaneously, intravenously or intraperitoneally. All of the parenteral routes are effective. In recent years the lining of the gastro-intestinal canal has been regarded as a barrier to the absorption of unchanged proteins. This belief was expressed by Abderhalden [1] in the seemingly cryptic statement that, owing to the profound digestive disintegration of the foodstuffs in the alimentary tract, our tissue cells never learn the true nature of the food we ingest. Admitting that absorption of unchanged protein through the intestinal mucosa or the mucosa of other surfaces might well serve to sensitize animals or man, recent writers [2] nevertheless still assert that the problem is not yet conclusively settled. Methods are at present available for detecting immunologic changes due to the absorption of foreign, that is, unchanged, dietary proteins. The accumulating evidence that under certain conditions the intestinal tract of infants is permeable to slightly altered or unaltered proteins has consisted in the demonstration of egg protein or milk protein in the blood or urine by means of precipitin or anaphylactic tests. This appears to be most likely to occur in malnourished infants or in those suffering from diarrhea. That antibodies may be produced under such circumstances is further made likely by the reports of Schloss and Anderson [3] at the Children's Hospital in Boston. Positive precipitin tests for milk protein in the blood were obtained in cases of severe diarrhea of infants. Whether the presence of reaction substances bears a causative relation to the clinical condition—a conclusion in harmony with many observations—or whether these evidences of reaction to cow's milk protein in the blood of athreptic infants is merely a sign of penetration of the intestinal barrier and entrance into the blood stream and a consequent formation of antibodies without direct etiologic significance, remains to be determined.

1. Abderhalden, Emil: Synthese der Bausteine in Pflanze und Tier, Berlin, 1912.

2. For example, Karsner, H. T., and Ecker, E. E.: The Principles of Immunology, Philadelphia, J. B. Lippincott Company, 1921, p. 211.

3. Schloss, O. M., and Anderson, A.: Allergy to Cow's Milk in Infants with Severe Malnutrition, Proc. Soc. Exper. Biol & Med. 20: 5 (Oct. 14) 1922.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION, PUBLIC HEALTH, ETC.)

ALABAMA

Hospital News.—Construction work has been commenced on the two new wards for the Bryce Hospital, Tuscaloosa, funds for which were made available by the legislature in 1919, but were only recently released by the governor. When completed the new addition will represent an expenditure of $150,000.——The new Madison County Home, Fegin Spring Cove, near Huntsville, was recently opened. All the occupants of the Huntsville poor house have been transferred to the county home.

ARIZONA

Personal.—Dr. Charles E. Irvin, Miami, has been appointed health officer of Gila County to succeed Dr. B. W. Hardy, who has removed to California.

COLORADO

Antivivisection Ballot.—It is said that the recent vote for vivisection (THE JOURNAL, p. 1620) was the largest ever cast on an initiated measure and the defeat was by a larger majority (5 to 1) than had ever been known before in the state. There were 35,416 votes against and 178,120 for vivisection.

Government Goes to Aid of Denver.—Dr. William Parran of the U. S. Public Health Service arrived in Denver recently following the request of Dr. William H. Sharpley, manager of the health board, and the City and County Medical Society, for help in suppressing the epidemic of smallpox prevalent in the city. The compulsory vaccination order was put into effect, November 14, and more than 85,000 persons were vaccinated by the city health officers. Of the 50,000 schoolchildren, only 275 have not been vaccinated. The disease reached

its crest during the week of November 11, when eighty-four new cases and nineteen deaths were reported. Since then the disease has gradually decreased.

CONNECTICUT

Yale University News.—In its new and enlarged quarters at 111 College Street, New Haven, the Bureau of Appointments of Yale University has completed the most active year of its existence, the director announces. Among the activities, many of which have been mentioned in THE JOURNAL during the year, was the raising of a special loan fund among the medical school students and graduates by Dean Winternitz, for the benefit of self-supporting students and graduates in that school who, because of laboratory requirements and heavy schedules, find it particularly difficult to earn any considerable part of their expenses.——The annual meeting of the Association of University Professors was held in New Haven, December 28-29, in connection with the annual meeting of the American Historical Association, the American Philological Association and the American Archaeological Association. Any member of these associations was invited to use the Faculty Club. A special supplement of the *Yale University Bulletin* was issued for the convenience of the various organizations meeting at the university during the holidays.

FLORIDA

Physician's License Revoked.—Newspaper reports state that the license of Dr. Charles D. Hulbert, St. Petersburg, has been revoked by the Florida State Board of Medical Examiners on the ground that he was found guilty of performing an illegal operation.

Antimosquito Conference.—More than 100 delegates representing twenty-one cities and towns in the state, four railroads, the Florida Development Board, the U. S. Department of Agriculture, the U. S. Public Health Service, the state board of health and various state and women's organizations, held an antimosquito conference in Daytona, December 7-8. An effort was made to organize a state association for eradicating the mosquito. Dr. Raymond C. Turck, state health officer, who presided, spoke on "The Purposes and Aims of This Antimosquito Conference." Col. Joseph Y. Porter, first state health officer in Florida, gave an address, which was followed by the motion picture, "Warfare on the Mosquitoes."

GEORGIA

Physician's License Restored.—A letter from the secretary of the state board of medical examiners states that the license of Dr. William P. Turk, La Grange, has been restored. The license had previously been revoked because of violation of the Harrison Narcotic Law.

Personal.—Dr. Herman W. Hesse and Dr. Edward C. Demmond have been elected president and secretary, respectively, of the Chatham County Medical Society. Dr. Hesse and Dr. James N. Carter have also been elected members of the city council of Savannah.——Dr. George R. White, Savannah, will take up his residence in the West on account of his health.——Dr. Harry B. Neagle, Augusta, has been appointed health officer of Augusta and Richmond County. ——Dr. Eugene E. Murphey has been reelected president of the Augusta Board of Health.

ILLINOIS

Hospital News.—A new county tuberculosis sanatorium will be erected in Joliet.——Plans have been completed for the erection of a hospital building at Bushnell at a cost of $100,000.——Joseph F. Miller has been appointed superintendent of the Methodist Hospital of Central Illinois, Peoria.

Pasteur Memorial Celebration.—On Tuesday, Dec. 26, 1922, the state health department gave a program in honor of the centennial anniversary of the birth of Louis Pasteur. The exercises were held in the senate chamber of the state house. Work was suspended in the department for an hour in order to give all members an opportunity to attend the celebration. A number of people from Springfield and vicinity were present.

Diphtheria Antitoxin Supply Low.—Field men of the department of public health are checking up on the diphtheria antitoxin stock of all distributing agents of the department, with the view of collecting all surplus supplies and placing them at points where supplies have been exhausted. This measure is necessary because state funds for purchasing antitoxin for free distribution have been completely exhausted.

Antivaccinationists Busy.—Field men attached to the state department of public health report that antivaccinationists are unusually busy in Illinois, vigorously opposing vaccination through every avenue of publicity open to them. Thousands of hand bills put out by the so-called "liberty league" are being distributed. Activities of this kind are concentrated, and are particularly vicious, at points where smallpox epidemics are most threatening.

Diphtheria on the Wane.—Reports to the state department of public health indicate that the peak of diphtheria incidence for the season was reached in November, during which a total of 2,297 cases was reported, as compared with 3,505 for the same month last year. To December 23, a total of 15,020 cases of diphtheria had been reported from the state, indicating that the total incidence for 1922 will fall 5,000 cases short of the total incidence last year, 20,793.

Communicable Disease Incidence Low.—With the year practically at an end, reports to the state department of public health indicate that the general communicable disease incidence will fall short of that for last year by more than 10,000 cases. To December 23, approximately 160,000 cases of all notifiable diseases had been reported from the state, as compared with 176,740 for 1921. Declines are especially noticeable in the incidence of diphtheria, scarlet fever, whooping cough, measles and smallpox. There were distinct increases in the reported prevalence of influenza and pneumonia, the heaviest incidence having occurred during the early months of the year.

Personal.—Dr. Alan G. Brooks has been appointed city physician of Robinson to succeed Dr. Leroy Newlin.——Dr. Samuel A. Graham, Clinton, has been appointed managing officer of the Lincoln State School and Colony to succeed the late Dr. C. B. Caldwell.——Dr. William R. Fringer has succeeded Dr. David B. Penniman as president of the Winnebago County Medical Society.——Dr. Ralph McReynolds and Dr. Arthur H. Bitter were elected president and secretary, respectively, of the Adams County Medical Society at the annual meeting.——Dr. J. S. Templeton, Pinckneyville, has been appointed district health superintendent to represent the state department of public health in Jackson, Perry, Jefferson, Randolph and Washington counties. This makes a total of twenty-one physicians attached to the field staff of the department.

Chicago

Pasteur Celebration.—At a meeting in which the Chicago Medical Society, the Chicago Chemical Society and other scientific organizations joined, the centenary of the birth of Pasteur was celebrated with a banquet at the Congress Hotel, December 27. Dr. Ludvig Hektoen presided and invocation was offered by Archbishop Mundelein. Addresses were delivered by Dr. Victor C. Vaughan, who discussed the life of Louis Pasteur and his work, and by the French consul in Chicago, M. Barthelemy.

Campaign Against Traffic in Drugs.—At a recent meeting of the executive council of the Chicago Medical Society, under the presidency of Dr. Hugh N. MacKechnie, a resolution was passed to enlist the 6,000 physicians of Chicago and Cook County in a campaign against the use of narcotics. The public information committee, of which Dr. Martin M. Ritter is chairman, will have charge of the society's activities. He will organize a speakers' bureau, composed of the leading physicians of Chicago and Cook County, to address various local groups and organizations and plead for organized action against the traffic. All members of clubs, fraternal organizations and societies will be requested to sign a petition to be addressed to the President asking a "national antinarcotic week" and the creation of a national antinarcotic conference for the suppression of narcotics.——John H. Montgomery and William J. Knick, proprietors of a drug store in State Street, Chicago, alleged to have conducted the largest illicit drug trade in the United States, were recently arrested after months of investigation by the federal authorities and are now on trial.

INDIANA

Hospital News.—The county commissioners have accepted plans for the erection of a tuberculosis sanatorium to be built at a cost of $350,000 near Crown Point. Work on the first unit will be commenced in the spring.

Personal.—Dr. Louis Severin and Dr. Clarence H. Mead, both of Bluffton, were elected president and secretary, respectively, of the Wells County Medical Society, recently.——Dr. William B. Kreider, Goshen, has been elected president of the Elkhart County Medical Society.——Major Larry B.

McAfee, Harrison, was decorated with the distinguished service medal by Brigadier General Aultman at Fort Benjamin Harrison, December 12.——Dr. James G. Royse, Indianapolis, has been appointed assistant state health officer to succeed Dr. W. F. King, who was recently appointed state health officer to succeed Dr. J. N. Hurty. Dr. Royse was formerly director of the bureau of venereal diseases of the state health department.

IOWA

Dubuque County Medical Society.—At the annual meeting of the society, December 12, Dr. Lilly Kinnier was elected president; Drs. Walter Cary and F. S. Leonard, vice presidents; Dr. Howard Thompson, secretary, and Dr. J. H. Schrup, treasurer.

Personal.—Dr. William Vernon Cone, Iowa City, has been awarded a fellowship as research worker in neuropathology by the National Research Council of the Rockefeller Foundation.——Dr. Eleanor M. Hutchinson, women's physician to the state epileptic colony, Woodward, has been appointed superintendent of the women's reformatory at Rockwell City.

Hospital News.—The Walker County Hospital has recently been incorporated by Dr. A. C. Jackson, who will establish a $75,000 hospital in Jasper, it is announced.——A new ten-story hospital building to be erected across the Iowa River is contemplated for the University of Iowa. When all units of the institution are completed the cost will be approximately $1,000,000.

Sioux Valley Medical Association Meets.—The Sioux Valley Medical Association will hold its fifty-fourth semi-annual meeting at the Martin Hotel, Sioux City, January 25 and 26. Drs. A. J. Ochsner, professor of surgery, University of Illinois; Martin Fischer, professor of physiology, University of Cincinnati; William Engelbach, professor of medicine, St. Louis University; Dean Lewis, professor of surgery, Rush Medical College; Clifford Grulee, professor of pediatrics, Rush Medical College; M. A. Blankenhorn of the Department of Medicine, Western Reserve University; J. S. Evans, Jr., professor of clinical medicine, University of Wisconsin, and Henry Schmitz and Lewis Bremerman of Chicago will be present.

KENTUCKY

Urologists Elect.—At the first annual meeting of the Louisville Urological Society, December 12, Dr. Henry J. Farbach was elected president; Dr. E. Owsley Grant, vice president, and Dr. Herman B. Strull, secretary-treasurer. It was announced that a Kentucky state urological society will be organized, to have a section in the state medical association meeting.

Hospital News.—Dr. Herbert T. Thornburgh, Toledo, Ohio, has been appointed assistant superintendent of the Eastern State Hospital, Louisville, to succeed Dr. Harry S. Seiwell. ——Dr. John W. Moore has been appointed medical superintendent of the City Hospital, Louisville.——A hospital building will be erected at the Old Folks' and Rebekahs' Home, Eminence, at a cost of $60,000.

LOUISIANA

Personal.—Dr. Arthur G. Heath, Shreveport, was recently appointed chairman of the local board of health. Dr. Thomas P. Lloyd was elected vice chairman of the board.——Dr. James W. Walsworth, Monroe, has been elected president of the Ouachita Parish Medical Society.

MAINE

Venereal Disease Clinic to Be Opened.—The city of Auburn will establish a venereal disease clinic in the near future under the direction of Dr. Leo F. Hall, city health officer.

MARYLAND

Personal.—Under the state reorganization plan, to go into effect January 1, Dr. John S. Fulton, secretary of the state board of health, will become director of health. The present board of health, consisting of Drs. William H. Welch, Benjamin B. Perry, William W. Ford, E. F. Kelly and Tolley A. Biays has been reappointed by the governor.——Dr. J. Knox Insley has been appointed commissioner of labor and statistics for Maryland, his appointment to take effect January 1.

Cornerstone Laid.—The cornerstone for the new hospital for infectious diseases for Baltimore city, at Lake Montebello, to be known as the Baltimore Municipal Hospital, was laid December 19. Seven buildings to constitute the first group are under construction and will cost approximately $643,000, exclusive of grounds and furnishings. The wards will be ready for occupancy by October 1. Dr. Birckhead MacGowan, superintendent of Sydenham, now the city infectious hospital, which will be abandoned, will become director of the new hospital.

MASSACHUSETTS

Schick Test for Medical Students.—Dr. John A. Ceconi, epidemiologist in the Boston Health Department, administered the Schick test to 135 medical students of Tufts College, December 13. The health commissioner has recently been lecturing on the advantages of the test.

MICHIGAN

Hospital News.—The new state tuberculosis sanatorium for inmates of Michigan's penal institutions will be occupied by the middle of January.

Professor Lombard Resigns.—Prof. Warren P. Lombard, for thirty-one years professor of physiology at the University of Michigan, has resigned at the age of 68 in order to devote his time to research.

Personal.—Dr. David Littlejohn has resigned as head of the health department of Ishpeming to become director of public health and welfare of Bluefield, W. Va.——Dr. David M. Kane has been appointed city health officer of Sturgis.

Mentally Deficient Autoists.—Of twenty-three persons charged with reckless driving who were examined by Dr. A. L. Jacoby, city psychiatrist of Detroit, December 20, to determine their sanity, three were declared mentally deficient. The examinations were ordered by Judge Bartlett, and sentences were witheld until the court had received the psychiatrist's report. One man charged with driving his car 32 miles an hour was found to be of inferior intelligence, nearly deaf and possessed of very poor eyesight. Another alleged speeder was unable to read English and stated that he could not differentiate between the "go" and "stop" signals at street intersections.

Michigan's Laboratories.——During the last fiscal year, the Michigan Department of Health laboratories sent out antitoxin to the value of $60,000. Had the individuals using this serum been compelled to pay the contract prices formerly made to cities, it would have cost them $412,800—6.88 times as much as it cost the state to supply it free of charge. Michigan's laboratories, the annual report shows, carried out 141,869 tests, at a total cost of $77,216.91. This is a larger number than any reported by state laboratories in this country, although three state laboratories, the New York, Massachusetts and California, receive larger sums for operation. Had this work been done in commercial laboratories, the cost would have been, approximately, $500,000. The Kahn test has been added to the routine work of the laboratories. Michigan is now the only state whose laboratory tests for this disease include a routine check on the Wassermann test. In 1919, when the bureau of laboratories was reorganized, its routine included but five examinations. Now, according to the report, it is equipped to carry out fifty kinds of biologic tests.

MINNESOTA

Personal.—Dr. Ernest G. Sterner, St. Paul, was recently elected president and Dr. C. L. Larsen, vice president, of the Ramsey County Medical Society.

MISSOURI

Chiropractor Convicted.—It is reported that August Meyer, a chiropractor of St. Louis, was found guilty recently of practicing medicine without a license, and fined $50 in the court of criminal correction.

University News.—By the will of Mrs. Hannah Duryea the St. Louis University has been bequeathed securities valued at more than $50,000 to be used for dispensary purposes in connection with the medical school, Dean Loeb announces.

NEW HAMPSHIRE

Hospital News.—Miss McLennan has been appointed superintendent of the Portsmouth Hospital, Portsmouth.——The Jones Hospital, Colebrook, will in future be known as the Colebrook Hospital.——Miss Stevens and Miss Bryant

have been elected superintendents of the Laconia Hospital, Laconia, and the Carrie F. Wright Memorial Hospital, Newport, respectively.

NEW JERSEY

Physician's License Revoked.—The New Jersey State Board of Medical Examiners reports that on November 23, the license to practice medicine and surgery of Dr. James F. Kerr, New York, was revoked on the charge of practicing criminal abortion.

NEW MEXICO

New County Health Officer.—Dr. Eugene O. Chimene, who resigned as health commissioner of Floyd County, Ga., to accept the same position in Greenville County, S. C., has recently been appointed by the New Mexico Bureau of Public Health as health officer of Union County, with headquarters at Santa Fe.

Personal.—Dr. Rollin M. Schwartz, full-time health officer of Santa Fe County, resigned recently to return to Cleveland. He is succeeded by Dr. Dudley B. Williams, Portales, who had been serving as full-time health officer of Torrance County, the work of which had to be discontinued on account of a severe drought that partially depopulated the county and which severely reduced its income.——Miss Margaret Tupper has resigned as supervising nurse of the Mexico State Bureau of Public Health, to take the public health nursing course at Columbia University, New York.——Dr. George S. Luckett, Santa Fe, state commissioner of public health, read a paper on "The First Three Years of Mortality Registration in New Mexico" before the first meeting of state insurance agents, recently.

NEW YORK

Hospital News.—The cornerstone was recently laid for the Wheel Chair Home for Incurables in Buffalo.——Forty additional acres of land have been obtained by the Home and Farm Institution for Mental Convalescents at Monticello, adjoining the seventy-three room hotel property recently purchased by the home. The farm will be utilized for occupational therapy for shell-shocked veterans of the World War and for mental incompetents.

New York City

Personal.—Dr. S. M. Evan recently returned from Europe on the steamship *Colombia* from Genoa and Naples.——Dr. F. G. Banting of the University of Toronto delivered an address before the New York Academy of Medicine on December 21 on "Pancreatic Extract in Diabetes Mellitus."

Tribute to Pasteur.—The centenary of the birth of Pasteur was celebrated on December 20 at the Waldorf Astoria by the Alliance Française of New York. M. Gaston Liebert, consul-general of France; Dr. Ernest Laplace, professor of surgery, University of Pennsylvania, and Prof. Andre Morize, Harvard University, were the speakers.

Pasteur Centenary.—A public exhibition of books, portraits, medallions and other objects relating to Pasteur will be held at the New York Academy of Medicine, 17 West Forty-Third Street, from 10 a. m. to 10 p. m., Dec. 27, 1922, to Jan. 10, 1923. At the commemorative exercises to be held at 8:30 p. m., January 10, the following addresses will be given: Prof. Russell Chittenden, Yale University, "Contributions of Pasteur to Chemistry"; Dr. William H. Welch, Johns Hopkins University, "Pasteur's Contributions to Biology"; Dr. E. F. Smith, U. S. Department of Agriculture, "Pasteur's Study of Silkworm Diseases"; Dr. Simon Flexner, Rockefeller Institute, "The Contributions of Pasteur to the Knowledge of Immunity and Therapy"; Dr. Herman Biggs, N. Y. State Health Department, "Pasteur and the Treatment of Rabies," and Dr. William W. Keen, Jefferson Medical College, "The Influence of Pasteur on Knowledge Concerning Surgical Infection and Puerperal Fever."

NORTH CAROLINA

Personal.—Dr. Eugene B. Glenn, Meriwether Hospital, Asheville, was recently elected president of the North Carolina Hospital Association.

OHIO

Personal.—Dr. Elmer O. Peterson, Canton, has been appointed a member of the city board of health by Mayor Curtis.

Hancock County Medical Society.—At the annual meeting of the society in Findlay, December 7, Dr. Don B. Biggs was elected president; Dr. A. Earl King, Mount Corey, vice president, and Dr. Earl J. Thomas, treasurer. Dr. Cornelia B. Kennedy was elected secretary for the fifteenth time. A banquet followed the business meeting.

PENNSYLVANIA

Philadelphia

Personal.—Dr. Richard A. F. Penrose, Jr., has been elected president of the Academy of Natural Science to succeed Dr. John Cadwalader.

Smallpox Quarantine.—For a third time within a few days a quarantine has been placed around a neighborhood in South Philadelphia. A cordon was drawn about the block from Fifteenth to Sixteenth streets, and from Wharton to Reed streets, and a corps of twenty physicians began vaccinating the residents.

Campaign for Funds for College.—The Philadelphia College of Pharmacy and Science is endeavoring to raise $2,000,000 for expansion of its work, and has already raised the sum necessary for a building site, which has been purchased. It is planned to use the $2,000,000 for a group of buildings, with equipment, and in providing an adequate endowment. Rear Admiral W. C. Braisted, formerly surgeon-general of the Navy, is the president of the college.

Hospital News.—The Conemaugh Valley Memorial Hospital, Johnstown, of which Dr. William Bailey is superintendent, has recently completed a nurses' home which will accommodate 125 nurses. It was formally opened November 3, with a reception for the public. It is a four story and basement structure, erected at a cost of $210,000, including furnishings. The latter were provided by the Women's Memorial Hospital Association. Building will be continued in the spring by the erection of a new hospital building.—— A hospital building will be erected at St. John's Lutheran Home at Mars.

SOUTH CAROLINA

Personal.—Dr. Clough H. Blake, Greenwood, was recently elected chairman of the local board of health.

Rural Sanitation Work.—During the past year, work has been conducted in eighteen counties in the state by the department of rural sanitation. Each of these counties had a full-time health department, and it is announced that the number of cases of typhoid and the infant death rate from intestinal disease decreased considerably. Nearly 400 public health lectures and 500 talks to schoolchildren were given, and nearly 15,000 homes were visited. Hookworm campaigns were carried out in four counties, and tuberculosis clinics were held throughout the territory. Of the 13,155 schoolchildren examined, 6,951 were found defective. A campaign will be conducted to establish a full-time health department in every county in the state.

TENNESSEE

Physician Violates Narcotic Act.—It is reported that Dr. J. Easterly Sproles, Bristol, was fined $100, December 11, in the district court at Abingdon, Va., on a charge of violating the Harrison Narcotic Law. The case of his brother, Dr. C. B. Sproles, also charged with illegally selling drugs, has been transferred to the Lynchburg docket, to be tried, Jan. 9, 1923.

Southern Surgical Association.—At the thirty-fifth annual meeting of the association held in Memphis, December 13-15, under the presidency of Dr. C. Jeff Miller of New Orleans, the following officers were elected: president, Dr. James F. Mitchell, Washington, D. C.; vice presidents, Drs. G. Battle Malone, Memphis, and Irvin Abell, Louisville, Ky.; treasurer, Dr. Urban Maes, New Orleans, and secretary, Dr. Hubert A. Royster, Raleigh, N. C. (reelected). White Sulphur Springs, W. Va., was selected as the meeting place for 1923.

Society News.—At the annual meeting of the Chattanooga Academy of Medicine, December 1, Dr. E. Dunbar Newell was elected president; Dr. H. Quigg Fletcher, vice president, and Dr. G. Victor Williams, secretary-treasurer. Dr. Willard Steele, the retiring president, gave a banquet, followin; the election of officers.——A number of America's outstanding educators, economists and welfare leaders appeared on the program of the home betterment congress of the Southern Cooperative League, held December 3-5, in Nashville, under the presidency of Dr. P. P. Claxton of the University of

Alabama, formerly U. S. Commissioner of Education. The purposes of this organization are to procure adequate appropriations for the advancement of public welfare, especially where it concerns public health and education; to promote law and order; to encourage proper social legislation, and to maintain a clearing house for gathering and disseminating information regarding social, educational and moral conditions in the South.

TEXAS

Three New Hospitals for Houston.—Three new hospitals will be ready for occupancy during 1923, it is announced. Work will be started immediately on the new unit of the Methodist Hospital; ground has been broken for the Hermann Hospital in Hermann Park, and the joint city and county hospital will be erected early in 1923 when $100,000 from the county's taxes becomes available. The Hermann Hospital, under the terms of the will of George Hermann, will be erected for those unable to pay hospital and surgical fees, while the city-county hospital will be for patients of Houston and of Harris County who are unable to meet these expenses. The first unit of the Hermann Hospital will cost approximately $200,000, and the same amount will be expended on the city-county hospital.

VIRGINIA

New Sanatorium Destroyed by Fire.—The Alleghany Sanatorium, Goshen, was destroyed by fire, November 30, at an estimated loss of between $100,000 and $150,000. The building was formerly used as a summer hotel, but was recently purchased by a corporation with a view to remodeling and opening it as a sanatorium.

New Medical Society.—A movement is on foot to organize a medical society along the Clinch Valley division of the Norfolk and Western and Louisville and Nashville railroads, composed of physicians from the counties of Tazewell, Buchanan, Russell, Dickenson, Wise and Lee. This society will be similar to the Southwestern Medical Society, comprising counties along the Norfolk and Western Railroad from Bristol to Roanoke.

PORTO RICO

Dr. Ashford Decorated.—In commenting on the awarding of the distinguished service medal to Dr. B. K. Ashford, the *Bulletin* of the Porto Rico Medical Association says: "This indefatigable worker for science and cultivator of affection is the model of the never wearying research worker, with his big heart open to all and for all, always scattering optimism wherever he passes." The medal was awarded in recognition of his distinguished services in France. Dr. Ashford's work, especially that with hookworm disease, is familiar to all in Porto Rico and elsewhere in Latin America.

Personal.—Dr. J. Capó has returned to San Juan, Porto Rico, after a trip to the United States and Europe.——Dr. Diego Biascoechea has also returned to Porto Rico from a trip to the United States.——Dr. Manuel Quevedo Baez, president of the Porto Rico Academy of Medicine, who has been in Spain for several months, has returned.——The *Bulletin* of the Porto Rico Medical Association mentions the arrival at San Juan of Dr. R. Townsend. He comes in response to the appeal made by the director of the Porto Rico board of public health to the American Red Cross for expert advice in the campaign against tuberculosis. Dr. Abel de Juan has been appointed as his assistant to accompany him on his tour of inspection throughout the island to determine the "tuberculosis index" of the country.

Alexander Righter Craig.—The *Bulletin* of the Porto Rico Medical Association pays tribute to the memory of "this good friend of the Porto Rico Medical Association and indefatigable worker for the American Medical Association of which he was the secretary at the time of the event we are mourning, his death, September 2. This good friend of our organization well deserves this small tribute of affection as he was the one who disinterestedly labored with the utmost earnestness to secure from the governing board of the American Medical Association the arrangements which allowed our organization to become affiliated with the association of which he was the secretary. Modest and efficient, he attended to the matters pertaining to his position with the zeal which is indispensable to give the impulse and sustain it through all the inconveniences inherent in such organizations." The board of the Porto Rico Medical Association under whose auspices the *Bulletin* is issued consists of Dr. Gutiérrez Igaravidez, president; Dr. R. López Nussa, vice president; Dr. Jacinto Avilés, treasurer; Dr. Agustín R. Laugier, secretary, and three councilors, Drs. F. J. Hernández, P. Malaret and H. López Sicardó.

CANADA

Medical Journals.—The *Canada Lancet* has recently incorporated the *Dominion Medical Monthly* and the *National Hygiene and Public Health Welfare Journal.*

Medical Association News.—The first clinical meeting of the Vancouver Medical Association was held recently in the Vancouver General Hospital, with Dr. J. J. Mason, the president, in the chair. The subject under consideration was "Acute Suppurative Otitis Media."

Alberta Medical Association.—At the annual meeting of the association, held in Edmonton, for three days recently, under the presidency of Dr. A. E. Archer, the following officers were elected for the ensuing year: president, Dr. Andrew F. Anderson, Edmonton; vice presidents, Drs. William Hackney, Calgary, and Edgar W. Allin, Edmonton; secretary, Dr. William H. McGuffin, Calgary, and treasurer, Dr. Thomas J. Costello, Calgary. Dr. Clifford R. Gilmour of Winnipeg presented a paper, and Dr. Alfred T. Bazin of Montreal delivered the lecture on surgery.

Public Health News.—Toronto's mortality rate for 1922 will be lower than that for 1921, according to the monthly report of the medical officer of health, who declares that, for the first six months of this year, the bureau of census at Washington, D. C., forecast a slightly higher rate for this year than that of last year. For the first six months of this year, Toronto's rate was 0.5 lower than the rate for last year, the deaths having continued to drop until the end of November, the probable annual rate stands at 10.4 per thousand, as compared with 11.2 for 1921. The chief cause of death in Toronto was organic heart disease, with cancer a close second. Infant mortality shows seventy-nine deaths for November this year as compared with ninety-three for last November, with a total of 896 for the first eleven months of this year and 1,132 last year. The total number of deaths during November, 1922, was 395, as compared with 445 for November, 1921.——A remarkable decrease in the number of cases of contagious disease is shown in the yearly report of the Sault Ste. Marie Board of Health, recently issued by the medical officer of health. He credits the low disease spread this year to precautions taken by the board of health. There was only one case of smallpox this year, while in 1921 there were 174 cases.——The city of St. John, New Brunswick, has recently installed a health center at Calverhill Hall. The building has been completely renovated and will house all civic health activities. The new health center will, to a considerable extent, serve the province as well as the city. Dr. Roberts, minister of health in the province, has declared that after May 1, 1923, all milk sold in the city must be pasteurized.

Personal.—Dr. George Vincent, president of the Rockefeller Foundation, recently addressed the Royal Canadian Institute at the University of Toronto on the subject of "International Medicine and Hygiene."——Prof. W. D. Tait, Montreal, has been appointed head of the psychologic clinic at McGill University, Montreal.——Dr. Hadley Williams, professor of surgery at Western University Medical School, London, Ont., read a paper on "Perforation of the Stomach and Duodenum" before a meeting of the second district of the Ontario Medical Association, in Kitchener, Ont., recently.——Dr. J. J. R. McLeod, professor of physiology at the University of Toronto and president of the American Physiological Society, read a paper on "Laboratory Contributions to the Study of Diabetes" before the annual meeting of the Academy of Medicine of Cleveland, Ohio, December 15.——Dr. John L. Todd of McGill University, Montreal, was recently decorated by Michel Straszewski, consul-general for Poland in Canada, with the Cross of Restored Poland, in recognition of his valuable services in research work for the Polish Republic. The Polish authorities claim that much of the successful campaign launched against the spread of typhoid in Poland was due to Dr. Todd's efforts.——Dr. C. M. Eaton of Vancouver, B. C., has recently assumed charge of the hospital in Atlin, B. C.——The following physicians have recently been elected fellows of the American College of Surgeons: Drs. Charles A. Young, Ottawa, Ont.; George C. MacIntyre, Toronto; Elmer W. Mitchell, Cobalt, Ont.; Robert V. B. Shier, Toronto; R. W. Irving and H. H. Murphy, of Kamloops, B. C.; J. W. Arbuckle, of Vernon, B. C., and W. H.

Lang, of Vancouver.——Dr. George E. Armstrong has been elected dean of the Medical Faculty in McGill University, Montreal.

GENERAL

A Warning.—A letter from Dr. H. Milton Conner of the Mayo Clinic, Rochester, Minn., announces that an impostor using his name is traveling about the country obtaining loans from physicians. Three such cases have so far been reported to Dr. Conner.

Southwestern Medical and Surgical Association.—At the annual meeting of the association in El Paso, Texas, recently, the following officers were elected: president, Dr. Roderick D. Kennedy, Globe, Ariz.; vice presidents, Drs. John R. Van Atta, Albuquerque, N. M., and Jesse R. Gilbert, Alamogordo, N. M., and Dr. Harry R. Carson, Phoenix, Ariz., secretary.

American Chemical Society Elects Officers.—Dr. Edward C. Franklin, professor of organic chemistry, Leland Stanford Junior University, has been elected president of the American Chemical Society, succeeding Dr. Edgar F. Smith of the University of Pennsylvania. Dr. Wilder D. Bancroft, Cornell University, was reelected a director of the society, and William Hoskins, consulting chemist of Chicago, was made a new director of the society. The following councilors-at-large for the period from 1923 to 1925 also were elected: Roger Adams, University of Illinois; G. N. Lewis, University of California; Dr. Ralph H. McKee, Columbia University, and Dr. William McPherson, Ohio State University.

Mortality from Typhoid Fever, 1921.—The Department of Commerce, through the Bureau of the Census, announces that there were over 8,000 deaths from typhoid fever in 1921 in the registration area, which comprises 82 per cent. of the total population of the United States. The death rate from this disease was 9 per hundred thousand population in 1921 as compared with 7.8 in 1920. Only nine states in the registration area show lower rates in 1921 than in 1920: California, 4.3 per hundred thousand population; Connecticut, 3.6; Maine, 7.6; Michigan, 7.7; Montana, 3.5; New Hampshire, 3.6; North Carolina, 12.0; Vermont, 5.4; Washington, 5.4. Of the eleven states having separate rates for negroes, the lowest adjusted rate for the white population in 1921 was 3.6 and the lowest for the colored was 1.9, both for New York State, while the highest adjusted rate for the white population was 24.8 for Kentucky and for the colored 40.7 for Tennessee.

Mortality from Diabetes, 1921.—The Department of Commerce, through the Bureau of the Census, announces that about 15,000 deaths in 1921 from diabetes mellitus were recorded in the registration area, which comprises 82 per cent. of the population of the United States. Within this area the death rate from diabetes per hundred thousand population was 16.8 in 1921 as compared with 16.1 in 1920. Adjusted rates which make allowances for differences in the sex and age distribution of the population in the various states are given. In the thirty-four states of the registration area, the highest adjusted rate (21.8) appears for New York and the lowest (6.4) for Tennessee. For the states with considerable colored populations adjusted rates have been calculated separately for the white and colored populations. In this group of eleven states, the highest adjusted death rate from diabetes for the white population is 21.5 per hundred thousand population for New York, and the highest adjusted rate for the colored population is 22 for Pennsylvania. The lowest adjusted rate for the white population is 6.4 for Tennessee and the lowest for the colored population is 4 for Mississippi.

Bequests and Donations.—The following bequests and donations have recently been announced:

Children's Hospital, Boston, $128,450, as the result of a drive for funds, $5,000 of which was donated anonymously.

New Methodist Episcopal Hospital, Philadelphia, $75,000 for the building fund, by an anonymous donor.

St. Luke's Hospital, Bedford, Mass., $40,000 for the establishment of a pathologic laboratory, the gift of an anonymous friend.

For a Catholic hospital at Wilmington, Del., $30,000; supplied by thirty donors giving $1,000 each.

Methodist Hospital of Southern California, Los Angeles, $10,000 roentgen-ray equipment for the new addition, through a friend of Dr. Rex Duncan.

Hale Hospital, Haverhill, Mass., $5,000, for the maintenance of a room and free treatment for poor patients; Haverhill Old Ladies' Home and the Children's Aid Society, each $1,000, by the will of Hazen B. Goodrich of Haverhill.

Rosary Hill Home, the cancer hospital at Hawthorne, N. Y., $5,000, by the will of the late Dr. Horatio R. Storer of Newport, R. I.

Seaside Home for Crippled Children, Long Island, $2,500, the proceeds of a benefit performance.

Jewish Hospital, Philadelphia, for the maintenance of the Rebecca Fleisher Solarium, $2,000, by the will of Ida F. Fleisher.

Women's Colleges in the Orient, $250, the proceeds of a benefit tea at South Bend, Ind.

Missionary nursing service in Maine and Alaska was provided for in the will of Jane A. Delano, a nurse, who died in France while with the American Red Cross.

Maine General Hospital, Portland, several thousand dollars, by the will of Anna M. Milliken, Scarboro.

Jewish Consumptive Relief Society, Denver, maintenance of a bed in memory of his sister, by A. Portfolio.

St. Mary's Hospital, Minneapolis, endowment of a free bed in memory of her two sons, by Mrs. Elizabeth Gilroy. It will be known as the Elizabeth Gilroy Endowment Fund.

Mount Carmel Hospital, Columbus, Ohio, a Carrara marble statue in memory of Sister M. Brendon, former superior of the institution, from members of the staff.

Maternity Hospital, Wilkes-Barre, Pa., the surgical instruments of the late Dr. Edward C. Wagner, valued at several thousand dollars, by his widow.

Research Institute of Cutaneous Medicine.—The Court of Common Pleas No. 5 of the City of Philadelphia has just granted an amendment to the charter of the Dermatological Research Institute, authorizing a change of name to the "Research Institute of Cutaneous Medicine." The phrase "Cutaneous Medicine" was adopted advisedly, as the research will be extended to the relationship of skin diseases and general disturbances of the body. This change of name was requested by reason of the sale of laboratories with its entire arsphenamin plant to the Abbott Laboratories of Chicago. The Research Institute of Cutaneous Medicine has purchased a property at the corner of Twenty-First and Pine streets, Philadelphia, which it is equipping for academic research work in dermatology, syphilology and cognate subjects, and which will be ready for occupancy about the first of the year. With the funds accruing from the sale of the laboratories, added to the value of the securities purchased with past profits, an endowment fund of almost three quarters of a million dollars will be available for research work. It is expected that this fund will be kept intact and that the interest therefrom will suffice to support research from year to year. While investigative work in dermatology is carried on in many hospital and university clinics here and abroad, this is the first institute of the kind to be endowed with a permanent fund for this branch of medicine. The manner of the creation of this endowment fund is also unique in the annals of medical history, it is stated. On the staff of the Research Institute of Cutaneous Medicine are: Dr. Jay Frank Schamberg, director; Dr. John A. Kolmer, head of the department of pathology and bacteriology; Herman Brown, B.Sc., chemist; Malcolm Harkins, V.M.D., bacteriologist; Charles Weiss, Ph.D., associate in experimental pathology; Dr. Joseph V. Klauder, fellow in experimental syphilology; Dr. S. S. Greenbaum, fellow in dermatologic pathology; Dr. Dorothy W. Weiss, fellow in bacteriology; Dr. Baldwin Lucké, fellow in pathology; Clara C. Kast, B.Sc., assistant in bacteriology; Carola Richter, assistant in research immunology; Anna M. Rule, assistant in research syphilology; Elizabeth Yagle, B.Sc., assistant in bacteriology, and Anna M. Leyde, technical assistant in bacteriology. On the board of directors of the institute are Mr. Herbert L. Clarke, former president of the board of trustees of the Polyclinic Hospital and College for Graduates in Medicine (new graduate school of medicine of the University of Pennsylvania); Dr. David Riesman, professor of clinical medicine in the University of Pennsylvania; Dr. Albert D. Ferguson, physician to the Widener Home for Crippled Children, and Dr. George W. Raiziss.

LATIN AMERICA

Personal.—Dr. J. M. Allende, one of the editors of the *Revista Médica de Cordoba*, Argentina, and of the *Revista de la Asociación Médica Argentina*, is now in this country visiting both Eastern and Western clinics. He is planning to take a postgraduate course in surgery.——Dr. Eliseo Ramirez has been appointed secretary of the Academy of Medicine of Mexico.——Dr. J. de Jesus González of León, Gto. Mexico, has just completed twenty-five years of active practice in ophthalmology. He celebrated the occasion by publishing a compilation of his most important papers on neurology.——Dr. G. Diaz Lombardo and Dr. Francisco Reyes of Mexico City have been appointed members of the Superior Board of Health.

Celebration of Pasteur Centennial at Buenos Aires.—The *Semana Médica* relates that the committee appointed by the city authorities to plan the tribute to the memory of Pasteur voted six different measures: (1) to change the name of Córdoba Street to Louis Pasteur Avenue; (2) to lay the cornerstone of the new Pasteur Institute building on the day of the centennial; (3) to erect six pavilions for chronic cases and convalescents at the Rodriguez Hospital; (4) to erect

a hospital in the suburbs for the tuberculous, to be called the Pasteur Hospital, placing the first stone on the day of the centennial; (5) to donate to the medical school a tract of ground for construction of a laboratory for the science of foods and dietetics, and (6) to place a silver tablet with a tribute from the city of Buenos Aires on the tomb of Pasteur in the Paris Pasteur Institute. The idea of erecting a statue of Pasteur in the grounds of the medical school was considered but was abandoned, as the national committee in charge of the tribute to Pasteur intends to erect a statue elsewhere. Iribarne urged collection of a fund for a prize to be awarded for the best monograph on Pasteur's life and works.

Organization of the Profession in Argentina.—Owing mainly to the efforts of Dr. Nicolás Capizzano, 25 per cent. of the physicians of Argentina have enrolled in the new organization to promote the financial, social and ethical interests of the profession. This Sindicato de Médicos publishes a breezy *Bulletin*, address, Soler 4829, Buenos Aires. It discusses the various matters affecting the profession, and reproduces the talks of the director and his aids as they visit different medical centers trying to rouse the profession to the necessity for making a common stand against abuses and exploitation by outsiders, and against quackery and nostrums, and raising the standards of the profession in general. The latest issue of the *Bulletin* contains an account of various quack practices, written by Dr. Nestor Mercader from personal observation, and a pharmacist writes of certain unprofessional practices among pharmacists. One of the aims of the organization is to compile a directory of Argentine physicians, and the *Bulletin* lists the names and addresses of those already enrolled. In display type, it keeps proclaiming that the isolated are unable to defend themselves. They are exposed to attack on all sides. The director recently visited Rosario at the request of the local medical society, and the *Revista Médica del Rosario* reproduces his address and reports the numerous enrolments which followed. He stated that Argentina has one physician to 1,500 inhabitants, about the same proportion as in Germany, where, he said, "the *proletariado médico* is already a fact."

FOREIGN

Indian Assistant Surgeons' Association.—The seventeenth annual conference of the All-India Sub-Assistant Surgeons' Association was held at Indore in December.

Exhibition of Medical Photography.—There is to be a national exhibition of photography at Geneva, Switzerland, opening May 11, 1923. Dr. A. Jentzer, rue de l'Université, Geneva, is in charge of the medical section.

Medical Men as Barristers.—Dr. R. St. G. S. Bond, surgeon commander of the Royal Navy, professor of hygiene, Royal Naval College, Greenwich, England; Dr. G. H. Dart, London, and Dr. W. W. Jameson, London, were called to the bar, November 17.

Nobel Peace Prize.—The Norwegian arctic explorer and zoologist, Prof. Fridtjof Nansen, has been awarded the Nobel Peace Prize for his work in relieving the starving populations of Russia and Asia Minor and for his endeavor to promote the brotherhood of nations.

International Union Against Tuberculosis.—The next meeting of the union will be held at Berne, Switzerland, in 1924. It is proposed to hold the 1926 meeting in the United States, under the presidency of Dr. Theobald Smith, director of the Rockefeller Animal Research Laboratory at Princeton, N. J.

Anthrax Prevention.—The International Advisory Committee on Anthrax, which has been set up in accordance with a resolution of the third session of the International Labor Conference, Geneva, in 1921, held a meeting in London, England, December 5, with Sir William Middlebrook in the chair.

Pasteur Scholarships.—A society has been organized at Copenhagen to endow scholarships for Danish medical men who wish to take a course of study at the Paris Pasteur Institute or similar institutions in any country. Dr. S. P. L. Sörensen is the president of the new society, and it is proposed to award the first scholarship on Pasteur's birthday.

Individual Psychology Congress.—The International Society for Comparative Individual Psychology met at Munich, December 8 to 10. The addresses and discussions concerned chiefly Adler's system of comparative individual psychology as applied to psychology, characterology, psychotherapy, pedagogics, welfare work for the young, and art. The secretary was Dr. Else Sumpf, Kaulbachstr. 75, Munich.

The Swiss Antivenereal Disease Society.—At a recent meeting of this society it was decided that the moving picture educational films on venereal diseases now being prepared by commercial firms should be presented under the auspices of the society, and that some physician should be present to introduce the subject, in order to maintain the scientific character of the propaganda. The society voted to take part in the international hygiene exposition at Strasbourg in 1923.

Congress on Experimental Psychology.—Our German exchanges mention that the eighth gathering is to be held at Leipzig, April 17 to 20, 1923. Addresses are to be presented by O. Selz on "Types of Personalities and Means to Distinguish Them"; by R. Sommer and J. Cohn on "Sex and Personality"; by W. Peters on "Heredity and Personality," and by F. Krueger on "The Conception of Structure in Psychology." For further particulars, address Prof. F. Krueger, Liviastr. 6, Leipzig.

Royal Society Medals.—The Royal Society has awarded one of the royal medals to Prof. J. Barcroft of Cambridge, for his researches in physiology; the Buchanan medal to Sir David Bruce for his investigations and discoveries in tropical medicine; the Copley medal to Sir Ernest Rutherford for his researches in radioactivity and atomic structure; the Davy medal to Prof. J. F. Thorpe for his work in synthetic chemistry, and the Darwin medal to Prof. R. C. Punnett, professor of genetics in the University of Cambridge.

Chair Endowed at Glasgow.—On the death, recently, of Mr. Gemmell, brother of the late Dr. Samson Gemmell, regius professor of medicine in the University of Glasgow, the fortune which passed to him on the death of Dr. Gemmell, amounting to approximately £100,000, has been bequeathed to various Glasgow institutions. The sum of £20,000 is left to the trustees of the university for the purpose of endowing a chair in the faculty of medicine or science, to be known as the Samson Gemmell chair. The choice of subject is left to the trustees. The remainder of the estate will be used to establish a permanent Gemmell Bequest Fund, its income to be applied to charities in Glasgow.

The Semicentennial of the "Progrès Médical."—This Paris medical journal was founded in 1873 by Bourneville, and it announced as one of its aims the promulgation of the rather novel idea of the necessity for supplementing clinical examination with experimental tests. The semicentennial of the foundation was celebrated recently by a banquet and concert, which assembled three generations of medical journalists, nearly a hundred in all. Prof. C. Richet presided at the banquet, and the history of the *Progrès médical* was reviewed by the present editors, Dr. M. Loeper, and Dr. M. Genty. This exchange has long been regularly indexed in the Foreign Current Literature department. Of late it has made rather a specialty of reproductions of bedside lectures by eminent clinicians, with footnotes to tell the final outcome of the cases.

Personal.—Dr. W. Hellpach, professor of psychology at the Technologic College at Karlsruhe, has been appointed *kulturminister* for the state of Baden. He is editor of the *Aerztliche Mitteilungen* and a leader in the organized system of graduate courses.——Prof. T. Rovsing of Copenhagen has been elected an honorary member of the Italian Urologic Society. He has also recently been made a commander in the Finnish "White Rose" order.——The *Policlinico* mentions the arrival at Rome of the fourteen public health officials of various nationalities who are on a tour of inspection of public health systems in different countries, under the auspices of the Rockefeller Foundation, at the request of the League of Nations. A number of addresses were made by Italian specialists; among others, Devoto, of the Clinic for Industrial Affections, spoke on the "Hygiene of Labor." The hospitals, colonies, sanitary systems, aqueducts and reclamation works were visited.——In addition to the other tributes to Professor Barduzzi on his retirement from the chair of dermatology and syphilology at the University of Siena, a gold medal was presented to him by the physicians of the Livorno district. He organized twelve years ago a regular course on the history of medicine, giving his services gratuitously, and this course he will continue.——The Marcel-Benoist Swiss prize commission has awarded the prize for 1921 to Dr. C. Brunner, director of the canton hospital at Münsterlingen, for his works on infected wounds.——Professor Hamburger was given an ovation by students and other friends on his return to Groningen after his two months' trip to this country. He is professor of physiologic

chemistry, physiology and histology at the University of Groningen, and he had been invited to deliver the Dohme lecture at Johns Hopkins University. He lectured also at Boston, Washington, Toronto and Montreal, giving a total of fourteen lectures, on eight different subjects. The Dohme lecture was on "The Increasing Importance of the Problems of Permeability in Biology and Medicine."

Deaths in Other Countries

Dr. **E. Jepson,** former mayor of Durham and at one time ship surgeon; November 13, aged 73.——Dr. **E. H. Eastwood;** had served as bacteriologist to the Deccan War Hospital, Poona, India; to the North Russian Expeditionary Forces and to the Royal Victoria Hospital, Netley; demonstrator of pathology in the University of Sheffield; November 13, aged 30.——Dr. **Thomas Lyle,** alienist; former superintendent of the Birmingham Asylum; at Newcastle-on-Tyne, November 15.

CORRECTION

Dosage of Ergot.—In the article by J. C. Hirst on "Cesarean Section" in THE JOURNAL, December 16, the author is reported as stating that the dosage of ergot used represents 2 grains of the crude drug to each cubic centimeter. This should be 2 grams.

Government Services

THE 1924 BUDGET AND ANNUAL REPORTS OF VARIOUS DEPARTMENTS

Following is a summary of matters pertaining to the public health with appropriations in these documents:

The estimates of appropriations for 1924 as contained in the budget amount to $3,078,940,331, which is $195,298,359 less than the appropriations already made for the fiscal year, 1923.

ESTIMATED APPROPRIATIONS, WITH COMPARISONS FOR PREVIOUS YEARS

	Estimated 1924	Estimated 1923	Actual 1922
Executive Office and Independent Establishments:			
U. S. Veterans' Bureau Salaries and expenses	$ 54,373,000	$ 34,416,909	$ 5,698,047
Compensation increase	.....	3,500,000	2,134,908
Vocational rehabilitation	120,000,000	140,000,000	178,809,861
Hospital facilities	5,000,000	6,000,000	1,000,000
Medical services	45,442,264	64,402,435	69,584,346
Department of Agriculture:			
Bureau of Animal Industry, meat inspection	$ 3,625,000	$ 3,610,000	$ 3,713,692
Bureau of Entomology, prevention of spread of moths	$10,000	$50,000	506,322
Bureau of Home Economics	45,000	45,000	.....
Enforcement of Packers and Stock Yards Act	380,000	387,000	155,759
Enforcement of Insecticide Act	110,000	110,000	105,095
Department of Commerce:			
Bureau of Census	$ 1,607,000	$ 2,198,000	$ 2,764,445
Interior Department:			
Bureau of Mines	$ 1,700,000	$ 1,515,000	$ 2,351,398
Bureau of Education	187,653	158,858	153,861
St. Elizabeth's Hospital	910,000	1,100,000	948,495
Territories:			
Care of insane in Alaska	187,653	158,858	153,861
Education in Alaska	325,000	320,000	296,618
Medical relief in Alaska	88,000	88,000	101,823
Suppressing liquor traffic in Alaska	9,000	9,000	14,803
Building and Grounds of Public Works	75,000	41,500	176,986
Howard University, Freedmen's Hospital	57,000	.....	.....
St. Elizabeth's	140,000	210,000	10,600
Columbia Institute for Deaf	9,500	8,500	.....
Special Funds:			
Alaska public schools	$0,000	$0,000	56,319
Trust Funds:			
Personal funds of St. Elizabeth patients	225,000	200,000	186,560
Indian Service:			
Support of schools	4,300,000	4,300,000	4,447,881
Pensions:			
Fees for examining surgeons	330,000	330,000	327,867
Department of Labor:			
Bureau of Immigration	$ 3,002,775	$ 3,280,774	$ 3,578,199
Children's Bureau:			
Maternity and child hygiene	726,000	648,000	390,560
Miscellaneous	317,000	316,924	77,180
Employment Service	220,000	231,189	200,396
Women's Bureau	100,000	99,000	75,422
Navy Department:			
Bureau of Navigation Naval Home, Philadelphia	$ 155,000	$ 158,000	$ 105,559
Bureau of Medicine and Surgery	2,265,000	3,029,000	3,566,812
Public works, hospitals and medical supply depts.	.....	300,000	.....
Naval Hospital Fund	3,364,637	3,500,000	2,408,116
State Department:			
Relief and protection of American seamen	$ 195,000	$ 200,000	$ 240,786
Rescuing shipwrecked American seamen	3,000	3,000	4,295
Prisons for American convicts in foreign lands	8,500	7,500	7,422
Treasury Department:			
Internal Revenue:			
Enforcement of prohibition and narcotic acts	$ 9,000,000	$ 9,250,000	$ 7,215,255
Public Health Service:			
Salaries and expenses	3,297,672	3,538,723	4,049,158
Prevention of epidemic diseases	334,792	399,750	574,462
Pay of personnel and hospital maintenance	4,878,925	5,611,394	3,801,658
Expenses, Division of Venereal Diseases	225,953	398,600	194,895
Public Works:			
Marine hospitals	15,000	500,000	166,393
Quarantine stations	.....	300,000	171,974
Hospital facilities and construction	1,200,000	8,000,000	10,852,995
War Department:			
Medical Department	$ 1,040,660	$ 845,899	$ 1,162,086
Soldiers' Home	5,785,000	5,833,800	9,690,515
District of Columbia:			
Health and sanitation	$ 2,522,667	$ 1,819,346	$ 2,126,459

Annual Report of Postmaster General for 1922

A part of the report of the postmaster general deals with the steps taken by the Post Office Department in bettering the individual health of the postal workers throughout the country. This was accomplished through an arrangement with the U. S. Public Health Service in fifty-eight cities throughout the country where postal employees were given the privilege of a voluntary medical examination by surgeons of the U. S. Public Health Service. The arrangement allows the examination of 100 employees a day in each of these cities. During last year also 985 volunteer postal workers were examined in New York and Chicago as a test, with the result that many defects were found in their eyes, teeth, tonsils and feet, and in their diet and their general physical condition. Mention is also made by Postmaster General Work in the annual report of a crusade to improve the physical working conditions in the post offices throughout the country.

Annual Report of War Department for 1922

There are several items of interest to the Public Health contained in the report of the War Department dealing with physical training and education:

Citizens' Military Training Camps.—During the year, twelve citizens' military training camps were conducted for the period of one month each. Attendance at the camps was purely voluntary. Instruction was provided by selected Regular Army officers and officers of the Reserve Corps. Medical officers, chaplains and hostesses were also on duty. Altogether, 40,697 applications were received, 11,202 of the applicants being authorized by the War Department to report, of whom 9,973 completed the course.

Education and Recreation.—The total enrolment at army post schools during the year was 13,460, which includes 8,365 in vocational courses and 5,095 in educational courses. The army personnel which served as instructors at post schools included 178 commissioned officers, nine warrant officers and 994 enlisted men. In addition, there were forty-four civilian instructors employed. An appropriation of $1,200,000 was made for the vocational education of soldiers during the year, of which $120,000 was saved.

Chemical Warfare Service.—The activities of the Medical Division of the Chemical Warfare Service during the year have been concerned chiefly with the investigation of the after-effects of warfare gases on both human beings and animals. A special study is being made of the development of tuberculosis as a result of gas exposure. Extensive arrangements are also being made for determining the action of gases on body metabolism, the blood and excretions of the body.

Annual Report of Navy Department for 1922

The principal features of the report of the Navy Department dealing with health include education in the naval establishment and the Navy Medical Corps.

The educational system has been expanded by the Bureau of Navigation during the last year to such an extent that 322 ships and stations were using the courses prescribed, with an approximate enrolment of 8,000 men.

The Bureau of Medicine and Surgery has continued its educational policy and special instruction. Three new schools are in process of organization, namely, a graduate school of dental medicine, school of aviation medicine, and a school of field service with marines. In spite of various attempts to obtain suitable candidates for admission into the Naval Medical Corps, few applications have been received, and the personnel is still short of its required strength. The Hospital Corps is approximately 600 under its authorized strength, the report states. The Navy Nurse Corps has continued to assist efficiently in the care of the sick in naval hospitals and on board hospital ships.

Annual Report of the Interior Department for 1922

The report of the Interior Department contains quite a number of items of public health interest:

Bureau of Education.—A reorganization of this bureau as effected during the last year, it is pointed out, has proved successful. Importance of the work in school hygiene and physical education has justified the employment of an additional specialist and an additional clerk. A new division of physical education and school hygiene was recently created. The rural schools division has done effective work circulating among rural school officers and others 25,070 leaflets and 20,300 circulars on subjects pertaining to rural school work. The division has also sent representatives into twenty-two different states for the purpose of investigating school conditions.

Care of Insane and Other Relief in Alaska.—At the close of the year there were 231 patients at the Morningside Hospital for the Insane in Alaska, an increase of fourteen patients over the preceding year. The sanatorium there has under construction a modern building to be used exclusively by the children. The work of education for the natives of Alaska has been successfully conducted. It includes the school service, the medical service and the reindeer service.

Eleemosynary Institutions.—St. Elizabeth's Hospital: There were 3,900 patients, as against 3,827 a year ago, representing an increase of seventy-three patients. There has been a steady improvement in the care and treatment of patients and the physical equipment of the institution.

Freedmen's Hospital: The number of patients under care totaled 3,553, as compared with 3,773 in the previous year, showing a decrease of 128. The physical condition of the hospital is reported as having been improved. One of the great needs, the report adds, is a laboratory building.

Columbia Institution for the Deaf: During the fiscal year there were under instruction in the advanced department of the institution, known as Gallaudet College, sixty-five men and forty-nine women, a total of 114, representing the District of Columbia, Canada and thirty-five states. This is a decrease as compared with the previous year. Of the total number in the Kendall School, forty-two were admitted as beneficiaries of the District of Columbia.

Maryland School for the Blind: Under this part of the report it is stated that the Secretary of the Interior has authority to issue permits for the instruction of blind children of the District of Columbia at this institution.

Annual Report of the Commissioner of Internal Revenue

The Prohibition Unit and the Narcotic Division are included in this report.

Prohibition Unit.—A complete reorganization of this unit occurred during the year with satisfactory results. The report shows that the number of employees in Washington increased from 503 at the beginning of the year to 596 at the close. In the field, the force was increased from 1,818 to 2,881.

Narcotic Division.—During the year the report shows that a total of 71,171 ounces of narcotic drugs and preparations came into the possession of the government through enforcing the internal revenue narcotic laws, an increase of 37,082 over the previous year. At the beginning of the year the narcotic field force consisted of 157 agents and inspectors, which number was increased to 176 during the year.

Foreign Letters

LONDON

(From Our Regular Correspondent)

Dec. 4, 1922.

Slander Leads a Physician to Attempt Suicide

Every physician has to endure at some time the slander of idle and evil tongues. Recently an elderly physician, who had retired from practice, attempted to perform a small operation for genito-urinary trouble on a widow, who was an old patient and friend. After ascertaining the exact condition under anesthesia, he proposed to swab with iodin. The woman expressed a wish that no one else be present in the room, a request to which he reluctantly consented. After a preliminary injection of one-sixth grain of morphin, he proceeded to induce light anesthesia with a mixture of chloroform, two parts, and ether, three parts. The patient took the anesthetic well, but after a few minutes stopped breathing. Resuscitation was attempted, and two other physicians were summoned; but the patient never rallied, and died nine hours after the induction. The physician had previously administered an anesthetic to the patient on four occasions, and although he knew that she was suffering from mitral disease with some hypertrophy and dilatation, he did not anticipate any trouble with the anesthesia. He gave a certificate recording the cardiac condition and stating that the cause of death was collapse after administration of an anesthetic. The certificate was accepted without demur, but the fact came out afterward that the physician was one of the patient's executors, and benefited to a considerable extent under her will, which was made many years ago. Then the voice of scandal was heard. At the funeral the remark was made that the physician had practically murdered her. Complaints reached the coroner, who ordered an exhumation and postmortem examination, to which the physician was not invited. He took a room at a hotel under an assumed name, where he was found unconscious from an overdose of sulphonmethane. He left a letter addressed to the coroner in which he said: "It seems clear from the action of the authorities and from their not inviting me to the postmortem on Mrs. Jelfs that some charge is contemplated against me, and this can only be of one nature, i. e., to show that I was interested in her death. The anxiety of the last few days, my dear wife's grief, and the blaze of posters in the evening papers, together with the importunities of the press, have rattled me to such an extent that I am going to sleep. I can be shown to be interested in the death, but was more interested in the patient's life, for it is known to others that she was on the point of making a new will which would have been to my advantage. With regard to motive, I wish to put forward that my wife's marriage settlement covered some $360,000, and she has never denied me anything." The physician recovered, and the necropsy on his patient completely exonerated him; but he was put on trial for attempted suicide, to which he pleaded guilty. The judge passed a sentence of four days' imprisonment, which meant that he was immediately discharged. The judge said that the case was particularly pathetic. The physician had behaved in a way that was entirely consistent with medical etiquette, and had done everything possible to save the patient's life. He condemned the scandal mongers and the statements in the press. He

stated that we do not recognize trial by newspaper in this country. He would not say that the physician's character had been reestablished; it had been doubly established. From the medical standpoint, the comment is obvious that the physician was imprudent in his own interest when he administered an anesthetic alone to a patient by whose death he was a beneficiary.

Surgeon Sued for Performing an Operation Without the Patient's Consent

At Capetown, a case came before the supreme court in which a surgeon was sued for $50,000 damages because he performed a serious operation for cancer in a public hospital without the patient's consent. He was, however, under the impression that the patient's consent had been obtained, and he maintained that the operation was the only method of preventing death. The plaintiff's lawyer argued that his client was entitled to refuse an operation and take the risk of death, and that the surgeon should have explained to him the necessity for operation and obtained his consent. The jury returned a verdict for the defendant.

Indian Medical Research

At the recent session of the Indian legislature at Simla, the assembly unanimously passed a resolution supporting a proposal of the governing body of the Indian Research Fund Association to establish an imperial medical research institute at Delhi. The association was founded in 1911, and has organized teams for research in various parts of India on leprosy, hookworm, deficiency diseases, kala azar, malaria, yellow fever and lathyrism. The results are published in the *Indian Journal of Medical Research*. It is now felt that there is need for a central institute where the best workers will coordinate the results. There is no lack of funds, even in these impecunious times. In addition to the government subsidy, certain anonymous donors in India have made generous contributions on condition that the institute will train Indians and create an atmosphere in which to cultivate Indian talent to cope with the medical and health problems affecting the people of India. After the scheme had been provisionally planned, the Royal Society was asked to nominate a leading specialist from home to investigate the proposal. Professor Starling, the occupant of the chair of physiology at University College, was accordingly sent out to India. He has reported in favor of a central institute made up of two separate parts—an institute proper and an institute of clinical medicine. In the former there should be established at once three sections, one on bacteriology, one on medical biology (to include entomology, protozoology and helminthology) and the third on biochemistry. Each of these should have a director with one or more assistants. Professor Starling also suggested that later on sections should be developed for pharmacology and medical statistics. For the institute of clinical medicine, he proposed a hospital of at least 120 beds with attached laboratories, which were to be chemical, bacteriologic and pathologic for graphic measurements and for cardiography and roentgenography. The whole unit he wished to place under a director with three assistants, one chemical, one bacteriologic and pathologic, and one clinical. He also held that the presidency towns of Calcutta, Madras and Bombay should develop their schools of tropical medicine, and that selected workers from these should be sent to the central institute at Delhi.

The Surgery of the War

The second of two volumes on surgery, which form part of the medical history of the war, prepared under the general editorship of Major General Sir W. G. Macpherson, has been published. It deals with special surgery as distinct from the more general surgery of the first volume. A dominating feature of war surgery, as revealed in the new volume, is the remarkable development of military orthopedics in the special military surgical hospitals. Restorative work, involving replacements of extensive bony losses to the face, jaw and limbs, and plastic operations for injuries to the face were carried out for the first time by the army medical authorities. Major General Sir G. H. Makins contributed the chapter on injuries to blood vessels. Remarkable results were achieved in three directions: joining the cut ends of vessels, stitching slits in injured vessels, and replacing interruptions in vessels by silver tubes for the temporary circulation of the blood. The last operation was learned from Professor Tuffier, with whom the British surgeons were in constant association. The tube is coated with paraffin, and though it becomes occluded it allows time for the collateral circulation to be established.

Sight Testing by Opticians

Sight testing and the prescribing of glasses by opticians are extensively practiced in this country, often with deplorable results. In 1906 and again in 1919, the opticians made applications to the legislature for the legal recognition of their craft for the purpose of sight testing. This has led to the issue by the Council of British Ophthalmologists of an important report on the subject. The council states that it would welcome any scheme which would lead to greater efficiency in the making and fitting of spectacles, and that it recognizes the need for greater supply of properly trained opticians. Ophthalmic surgeons have often to deplore the inefficiency displayed in carrying out their prescription of glasses. The opticians state that a large majority of persons desiring refraction visit them rather than ophthalmic surgeons, and their association argues that it is in the public interest that the optician should be a skilled man and under supervision. A qualified optician, they say, would recognize a case in which the eye could not be properly treated by glasses, and would refer the patient to a physician. But the Council of British Ophthalmologists rejoins that no course of training short of full medical qualification can secure the skill necessary for this. In their opinion, state recognition of sight testing by persons possessing only an optical qualification would not be in the interests of the public. Changes in the refraction are often produced in the early stages of serious eye disease, and in many of these the optician may be successful in raising the acuteness of vision to normal, but almost inevitably he would fail to recognize the disease. Indeed, disease serious to the eye and even threatening life may occur with perfect central vision. An adequate examination of the eyes and determination of the refraction cannot be made in young children without the use of mydriatics. These cannot be used in an indiscriminate manner, and in certain diseases of the eye they are dangerous. The treatment of headaches associated with errors of refraction demands not only the use of glasses but also constitutional treatment which can be given only by a physician. The sight-testing optician endeavors either to supply spectacles with which the customer considers he can see to his liking, or to provide such lenses as will make the eye focus accurately. All are agreed that the former procedure is indefensible. As to the latter, the eye is an integral part of the body. Without exposing it to the greatest danger it cannot be dealt with as an inert, isolated optical instrument.

Rat Conference

A rat conference, attended by health officers and other officials, has been held in London to inaugurate the fourth "annual national rat week." Mr. E. C. Read, technical adviser on rat repression to the ministry of agriculture, opened the discussion. He said that in this country we had

only played with the question of rat and mouse destruction. Our commerce made us a great center of rat attraction. Rats came ashore from the ships to the docks and warehouses, and then migrated to the cities, where they had an excellent means of communication through the sewers. If the sewers were not kept clear, the buildings never could be. He suggested that the health authorities of London and the surrounding counties of Middlesex, Essex, Surrey and Kent organize a unified scheme for the treatment of the sewers in that area. All metropolitan boroughs bordering on the river Thames should employ a whole-time rat catcher, whose services should be at the disposal of occupiers of infested premises.

Sir Frederick Andrews (pathologist, St. Bartholomew's Hospital) emphasized the danger of using a bacterial virus for the destruction of rats in urban districts. Professor Bainbridge had experimented with a large number of rat viruses and found that he was able to kill from 30 to 60 per cent. of the rats fenced in an area under natural conditions. But the surviving rats acquired immunity from the viruses. The viruses used came under two heads: one was a variety of the bacillus of Gaertner, which in man caused a considerable number of cases of food poisoning; the other, *Bacillus aertrycke*, also affected man. During the autumn, there had been in this country a considerable number of cases of food poisoning which had affected small groups in one household and were traced to one or the other of these bacilli. Some years ago, a large number of men employed in a drapery store and living on the premises were taken ill with abdominal pain, diarrhea, vomiting and pyrexia. Women employed at the same establishment and living in a different part of the premises were not affected. In the men's premises, but not in the women's, a rat virus had been used. In country districts, rat viruses might justifiably be employed, but in urban districts they should not; reliance should be placed on the use of barium carbonate and squills.

PARIS

(From Our Regular Correspondent)

Dec. 1, 1922.

Public Health Statistics in France

The minister of public health has commissioned Dr. Raoul Pacaud to make a critical study of the public health statistics of France. With a view to ascertaining the methods that are employed in the various regions of France in the collection of statistics on public health, Pacaud communicated with 674 municipalities, large and small, throughout the country. He received 600 replies. Of these 600 communes, 267 stated that no medical certificate accompanied the declaration of death. Of the 333 communes in which the execution of a medical certificate is customary, fifty-one require that it shall be made out by a public health officer; in 220 it is prepared by the attending physician, while sixty-two do not require a statement of the cause of death. The mayors of the communes in which the deaths are reported by public health officers admitted that the public health statistics could not be relied on for their accuracy, no matter how conscientious the public health officer was in fulfilling his duties, for the reason that it is difficult for him to secure accurate information on which to base his retrospective diagnosis. It would seem, therefore, that the best method is to require the attending physician to make out the death certificate; but the right of privileged communication with one's physician plays an important rôle in France.

The characteristic features of the system in use at Arcachon (which has since been adopted by several more important towns, for instance, Clermont-Ferrand and Pau) are these: The declaration of death is based on a certificate of the attending physician, which certificate consists of three parts: (1) one section is intended for the public health officer and bears the name and age of the deceased and the date of death; (2) a second section is intended for a physician who is designated by his confrères to record the statistics; the name of the deceased is omitted but the name of the disease causing the death is given; also all the demographic information needed is supplied; this second section must be forwarded under seal by the attending physician, immediately after the death of the patient, to the physician in charge of the statistics; (3) the third section is in the nature of a memorandum which the attending physician keeps; he may add any matters of information that he desires, which will later prove of great value for general reference. This system seems to guarantee a maximum of accuracy, and respects, at the same time, the right of privileged communication.

The International Conference on Serums

The second Conférence sérologique internationale, which was convoked by the League of Nations Health Conference, has just been held in Paris in the Pasteur Institute. Dr. Roux, director of the Pasteur Institute, congratulated the members of the conference on the important progress that had been made in the standardization of serums and serology. These countries were represented: France, Great Britain, United States, Japan, Belgium, Austria, Denmark, Germany, Poland, Roumania, Russia and Switzerland.

Professor Bordet and Professor Ehlers

During the recent ceremonies in connection with the fall opening of the University of Paris, Dr. H. Roger, dean of the Faculté de médecine, announced that Professor Bordet of the University of Brussels and Professor Ehlers of the University of Copenhagen had been granted by the Faculté de médecine the title of doctor of medicine *honoris causa*. Roger made reference to the many new ideas that Bordet's researches had brought to science, and to the immense service that his discoveries had rendered humanity. The original work of this scholar, whom he referred to as "one of the greatest biologists of the present age," was awarded the Nobel prize at the suggestion of the Faculté de médecine of Paris.

Professor Ehlers studied in France, having completed at the Saint Louis Hospital in Paris, nearly forty years ago, his studies in dermatology. He has devoted himself chiefly to the campaign against leprosy. During the war, he gave liberally of his time and energy to the support of the French cause, having organized and directed the Danish auxiliary ambulances in Belgium, France, Poland, Russia and Serbia. He helped organize movements in favor of France, and aided also in the repatriation of French prisoners.

A Pasteur Tag Day

At the suggestion of the *Bienvenue française*, a special tag day will be set apart in connection with the commemoration of the centenary of Pasteur. The funds collected will be turned over to the Academy of Sciences, which will distribute them among French scientific laboratories.

Modifications in the Regulations of the Academy of Medicine

At a recent session the Academy of Medicine discussed in a secret committee meeting a number of changes in its regulations. Among the proposed reforms, the plan of bestowing the title of "honorary member" on academicians who, for reasons of health or owing to the fact that they reside at a distance, are never present at the meetings, in order to be able to admit new members who would be more active, did not meet with the support of a majority. However, the academy decided to make extensive changes as regards the

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distribution of members among the various sections. The eleven sections existing at present are to be reduced to six, the lines of which will not be so closely drawn, so that it will be possible to admit to membership specialists for whom, under the present condition of affairs, it is difficult to find places.

BERLIN

(From Our Regular Correspondent)

Dec. 2, 1922.

Injurious Effects of Hypnosis

Prof. H. Schultz, formerly an assistant of the Jena psychiatrist Professor Binswanger, but now director of the Lahmann Sanatorium at the "Weisse Hirsch" near Dresden, published recently an enlightening article on the injuries to health caused by hypnosis. By hypnosis we mean, of course, the bringing about of a changed consciousness through the influence of words and other forms of suggestion. The suggestion is transmitted through the application of highly uniform stimuli; for instance, through fixing the gaze on a certain point or by looking the suggestor fixedly in the eye (fascination); by slow, uniform strokes or passes applied to the body of the subject, as is done in representations of animal magnetism, and by still other methods. Everything depends on the will of the subject. Only subjects that voluntarily place themselves at the disposal of the operator or those that are more or less influenced by embarrassment, fear, unrest, mystical clouding of judgment, and the like, are brought by these measures into an hypnotic state, in which various manifestations are produced according to whatever turn the operator gives the situation. Frequently, when the subject has come out of the hypnotic state, he has only a dim recollection of what has occurred. Especially characteristic for hypnosis is an extraordinary receptivity for ideas (heightened suggestibility). While it is true that even in a waking condition every thought has the tendency to be translated into some manifestation of the will or the emotions, this tendency toward realization becomes in the hypnotic state extremely accentuated. The higher qualities of the mind, such as judgment, self-determination and clear orientation, are, in the hypnotic condition, beclouded and inactive. Just as, in the waking state, a purpose does not occupy permanently the consciousness of the willer but breaks its way through only after the lapse of a certain length of time, so it is with the realization of ideas received while in a hypnotic state; they often appear after a long time has elapsed, and their origin remains obscure to the one who experiences them. For instance, the hypnotized subject is told to be present in a few days at a certain place at a certain hour. He does as he is told, but usually avers that he did not know that he was acting under hypnotic influence, and assigns other reasons for his actions.

It would be an entirely false conception to conceive of these manifestations as merely a harmless play of the imagination. A living man is an organic unit, and emotions that are called forth in a hypnotized subject cause distinct and pronounced variations in metabolism. For instance, if the suggestion is given the subject that he is swallowing milk, the gastric secretion will be different from that produced if the suggested fluid is bouillon. While these phenomena are analogous to those occurring in the waking condition, there is one manifestation that is characteristic of hypnotic experiments, the reversing of consciousness. Hypnosis is an experiment on the brain. Therefore, no conscientious physician will hypnotize a subject unless he has good reason to do so, any more than he would perform a surgical operation unless the indications were present, and the conception that hypnosis is based on cerebral changes, and the evidence of the accompanying accentuated general bodily modifications make it readily understood that careless playing with these things in unsuitable cases may lead to grave injuries to health. These injuries consist of unpleasant after-effects, such as a feeling of pressure in the head, dizziness, disturbances of sleep, disturbances of speech, and a state of motor or nervous excitement, and are due either to false technic or—which is even more serious—to the selection of unsuitable subjects for the experiment.

Nervous persons of all kinds, especially if there is a disposition to mental disease, may become seriously ill if they are the subjects in ill advised experiments in hypnotism. For hypnotic experiments only such persons may be employed as have been declared suitable by physicians familiar with the conditions. The layman is entirely incapable of passing judgment in this matter. Any knowledge of the subject that is worth while can be obtained only by special and thorough scientific training, and any person who jeopardizes the health of his fellow men by instituting, under the guise of experimentation, sensational stunts in hypnotism is criminally culpable. Mental disturbances lasting several months as the result of hypnosis applied to unsuitable subjects are fully attested, and there have been numerous penalties imposed on hypnotic operators on account of the impairment of the health of their subjects.

Besides the dangers to health, there are grave social dangers associated with an improper use of hypnotism. Hypnotic experiments if abused may easily lead to the enslavement of a subject, which may be taken advantage of by unscrupulous persons. The question whether a person in a hypnotic state may be induced against his will to commit a crime through automatic compliance with a suggestion does not seem to present very serious aspects. Schultz thinks that such a thing would be impossible.

A Scheme of Automatic Fee Adjustment

Since the cash fees that physicians receive for their services these days, partly on account of the depreciation of the circulating medium and partly owing to the high prices of foodstuffs, are often insufficient to pay their living expenses, they often resort in agricultural regions to the scheme of accepting payment in kind for their services. For instance, the physicians in Allgäu, Bavaria, have made butter the basis of their liquidations. For every consultation during their regular office hours they exact 1 pound of butter, and for a domiciliary visit they require 1½ pounds of butter to be furnished them. In the Rhine Province the physicians have made wheat the basis of payment. For an office consultation the minimum charge is 3 pounds of wheat; for a call in the home they figure 5 pounds of wheat; for a double kilometer of extra mileage they demand 1½ pounds; for a confinement, 50 pounds, and for the management of premature birth, 25 pounds.

Marriages

DANIEL E. BERNEY, Scranton, Pa., to Miss Rose Marie Quittelier of Brussels, Belgium, in Brussels, October 30.

THOMAS C. WITHERSPOON, Butte, Mont., to Miss Rita De Courtney of Anaconda, December 15.

PHILIP CHILDS POTTER, New York, to Miss Zaidee Tillinghast, Milton, Mass., December 16.

WILLIAM A. BRADSHAW, Pittsburgh, to Miss Helen Logan of Carnegie, Pa., October 28.

SIMON LEONARD VICTOR to Miss Doris D. Levy, both of Pittsburgh, November 30.

LAURENCE M. CODORI to Marie A. Silk, both of Philadelphia, November 30.

Deaths

John Edwin Owens, Chicago; Jefferson Medical College, Philadelphia, 1862; died, aged 86, from bronchitis, at his home in Chicago, December 21. Dr. Owens was born in Charleston, Md., in 1836. Following his graduation he entered the medical service of the Union Army and was assigned to duty in Chicago. He became attending surgeon at St. Luke's Hospital in 1865, continuing in this capacity until 1912, when he became consulting surgeon. He was chief surgeon of the Illinois Central Railroad from 1869 to 1911, and of the Chicago and Northwestern Railway continuously since 1888. He also served as medical director of the Chicago Exposition in 1893. He was professor of orthopedic surgery in Rush Medical College from 1879 to 1882, of the principles and practice of surgery in the Women's Medical College from 1877 to 1883, and of the principles and practice of surgery in the Chicago Medical College. At the time of his death he was emeritus professor of surgery in Northwestern University. Dr. Owens was well known as a writer on surgical subjects and was prominent in medical and surgical organizations throughout the country.

Henry Whitman Kilburn, Lucerne, Switzerland; Medical School of Harvard University, Boston, 1884; member of the Massachusetts Medical Society; the American Ophthalmological Society and the New England Ophthalmological Society; formerly ophthalmic surgeon to the Carney Hospital, Boston, and instructor in the Boston Polyclinic; aged 65; died, December 4, in Los Angeles.

Joel W. Fithian ✱ Camden, N. J.; Jefferson Medical College, Philadelphia, 1887; member of the Philadelphia Pediatric Society; superintendent of the Sunny Rest Sanitarium, Ancora; formerly obstetrician to the Cooper Hospital; member of the board of health; at one time county coroner and member of the city council; aged 58; died, December 9.

Albert Ralston Matheny ✱ Pittsburgh; Jefferson Medical College, Philadelphia, 1898; member of the American Association of Industrial Physicians and Surgeons; served in the M. C., U. S. Army, during the World War; on the staff of the Presbyterian and chief surgeon of the Pittsburgh Hospital, where he died, December 9, from pneumonia, aged 48.

Jesse Montgomery Mosher, Albany, N. Y.; Albany Medical College, Albany, N. Y., 1889; clinical professor of mental diseases at his alma mater; member of the Medical Society of the State of New York; American Neurological Association and the American Psychiatric Association; aged 58; died suddenly, December 7.

Jasper D. Fitch, Mohawk, N. Y.; Medical Department of the University of the City of New York, 1872; member, and at one time president of the board of education; author of "A History of Herkimer County" and many other works; aged 73; died, December 5, at the Masonic Home, Utica, from injuries sustained in a fall.

Lodrick M. Jones, Milledgeville, Ga.; Atlanta Medical College, Atlanta, Ga., 1878; member of the Medical Association of Georgia and the American Psychiatric Association; for twenty-five years on the staff, and for fifteen years superintendent, of the Georgia State Sanatorium, where he died, December 7, aged 72.

Warren David Calvin ✱ Fort Wayne, Ind.; Rush Medical College, Chicago, 1895; formerly professor of dermatology and physiology at Fort Wayne College of Medicine; served in the M. C., U. S. Army, during the World War, with rank of captain; aged 55; died, December 6, from arteriosclerosis.

Martin N. Triplett, Floodwood, Minn.; University of Louisville Medical Department, 1895; village president; member and president of the board of education; at one time member of the North Dakota state legislature; aged 56; died, December 8, from myocarditis.

John Gilbert Phillips ✱ Northfield, Minn.; Northwestern University Medical School, Chicago, 1905; formerly city physician; aged 45; died, November 27, at St. Mary's Hospital (Mayo Clinic), Rochester, following an operation for biliary calculi.

Edwin Thompson Bruce ✱ Louisville, Ky.; Hospital College of Medicine, Louisville, 1905; served in the M. C., U. S. Army, during the World War; aged 42; died, December 4, following an appendectomy.

Samuel Ramsey Milliken, Dallas, Texas; Columbia University College of Physicians and Surgeons, New York, 1902; served in the M. C., U. S. Army, during the World War; aged 43; died, December 3, in Washington, D. C., following a long illness.

Miller Royal Whitenack ✱ Newark, N. J.; Columbia University College of Physicians and Surgeons, New York, 1900; a member of the New Jersey Pediatric Society; aged 48; died, December 12, at the Presbyterian Hospital, from septicemia.

Henry Orendorf, Louisville, Ky.; Kentucky School of Medicine of Louisville, 1871; formerly professor of cutaneous, venereal and genito-urinary diseases at the University of Louisville Medical Department; aged 79; died, December 7.

Enrique V. Agramonte, New York; Bellevue Hospital Medical College, New York, 1872; formerly of Cuba; consulting ophthalmologist to the French Hospital; aged 77; died, December 4, from myocarditis and pulmonary edema.

Alexander R. Mitchell, Hereford, Md.; University of Maryland School of Medicine, Baltimore, 1877; member of the Medical and Chirurgical Faculty of Maryland; aged 67; died, December 12, at the Mercy Hospital, Baltimore.

George Ashton Bardsley ✱ Philadelphia; University of Pennsylvania School of Medicine, Philadelphia, 1897; formerly on the staff of the St. Christopher Hospital for Children; aged 47; died, October 26.

Albert J. Remsberg, Warfordsburg, Pa.; University of Maryland School of Medicine, 1874; a practitioner of Warfordsburg for more than a half a century; aged 76; died, December 7, from senility.

T. Mitch Anderson, Mountain View, Mo.; College of Physicians and Surgeons, Keokuk, Iowa, 1881; member of the Missouri State Medical Association; died, November 2, from cerebromeningitis.

Fuller S. Derr, Watsontown, Pa.; Jefferson Medical College, Philadelphia, 1884; member of the Medical Society of the State of Pennsylvania; aged 62; died, December 6, from acute indigestion.

John Jewett Darby, Port Townsend, Wash.; University of Oregon Medical School, Portland, 1918; on the staff of the U. S. Marine Hospital; aged 32; died, December 8, from appendicitis.

Charles Burr Caldwell ✱ Lincoln, Ill.; St. Louis University School of Medicine, St. Louis, 1905; managing officer of the Lincoln Home and Colony; aged 43; died suddenly, December 17.

Abraham Lincoln Burson, Irwin, Ohio; Ohio Medical University, Columbus, 1896; member of the Ohio State Medical Association; aged 56; died suddenly, December 3, from heart disease.

Addison E. Cattron, Sharpsville, Pa.; Cleveland Medical College, 1894; member of the Medical Society of the State of Pennsylvania; aged 60; died, December 6, from pneumonia.

George Ewh, Talmadge, Neb.; University of the City of New York, 1878; member of the Nebraska State Medical Association; aged 68; died in December, from heart disease.

Louis Daniel Joseph ✱ Bradford, Pa.; Jefferson Medical College, Philadelphia, 1904; aged 43; shot himself accidentally while cleaning his gun, November 23.

Peter B. Davis, Earlington, Ky.; Vanderbilt University Medical Department, 1876; formerly member of the state legislature; aged 66; died, December 4.

George Frederick Speiser, Los Angeles; Northwestern University Medical School, Chicago, 1921; aged 36; died, December 11, in Chicago, from tuberculosis.

Charles Bruff Downing, Genoa, Ohio; Toledo Medical College (Medical Department Toledo University), Toledo, Ohio, 1913; aged 46; died, December 3.

David R. Stout, Butler, Tenn.; Medical Department University of Tennessee, Memphis, 1891; aged 62; died, November 7, from uremia.

Charles F. Poppele, Decatur, Ill.; Eclectic Medical Institute, Cincinnati, 1874; aged 82; died, December 7, from acute atrophy of the liver.

Jerome S. Beeler, Evansville, Ind.; Hahnemann Medical College and Hospital of Chicago, 1883; aged 73; died, December 10.

Nelson S. Westcott, New York; Medical Department of Columbia College, New York, 1865; aged 81; died, December 4.

John A. Meskimen, Allison, Ill. (licensed, Illinois, 1878); Civil War veteran; aged 79; died, December 3, from senility.

Loren R. Simpson, Richmond Dale, Ohio; Eclectic Medical Institute, Cincinnati, 1879; aged 69; died, December 9.

The Propaganda for Reform

IN THIS DEPARTMENT APPEAR REPORTS OF THE JOURNAL'S BUREAU OF INVESTIGATION, OF THE COUNCIL ON PHARMACY AND CHEMISTRY AND OF THE ASSOCIATION LABORATORY, TOGETHER WITH OTHER GENERAL MATERIAL OF AN INFORMATIVE NATURE

TWO ELECTRONIC DIAGNOSES

The Reactions of a Guinea-Pig and a Sheep to the Reaction of Abrams

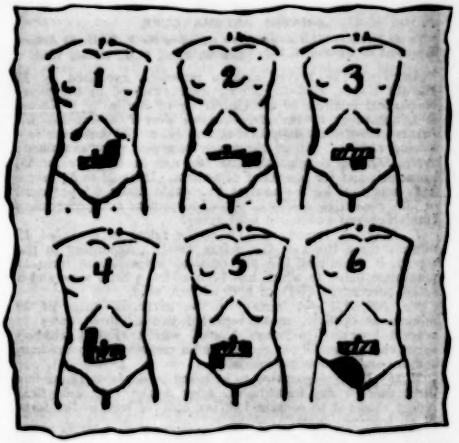
"A friend of mine, and an enthusiastic patient of one of the apostles of Dr. Albert Abrams, urged that I send a specimen of blood for diagnosis." Thus writes Dr. J. E. Hughes of Shawnee, Okla., who sends us the diagnosis sheet that was received from one J. W. Eisiminger of Oklahoma City who operates a "Physico-Clinical Laboratory for the Electronic Reactions of Abrams." Eisiminger, like many of Abrams' disciples, is not a physician but an osteopath. The report made by the osteopath on the specimen of blood sent in by Dr. Hughes reads as follows:

> "Congenital diminished resistance, cerebro-spinal and digestive strain, 39 ohms, Metastatic Carcinoma. 6 Liver and right colon, Tuberculosis Genito-urinary tract, 6 ohms. Colisepsis. 4 ohms. streptococci, infection, 12/25 ohms. in gall bladder region."

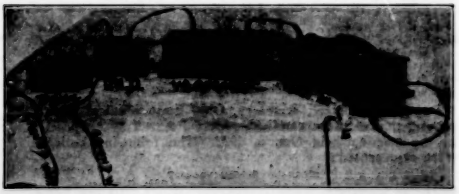
If, after reading this diagnosis, you feel a little bit dazed and are not quite sure just what it means, do not blame THE JOURNAL—we don't either. It is copied, just as given, from the typewritten report furnished by Eisiminger. One gets the impression that the patient was in bad shape. "Metastatic carcinoma," "Tuberculosis genito-urinary tract," "Colisepsis," a streptococcic infection in the gallbladder region —all sound portentous and disquieting. But on reading further in Dr. Hughes letter we learn: "The specimen was not from Mr. P————, whose history was sent with it, but was obtained from one of our unsuspecting and believed-to-be virtuous female guinea-pigs. The pig was duly arranged facing west when the blood was taken." In closing, Dr. Hughes mentions that the collection of the blood specimen was witnessed by three physicians and that, in view of the diagnosis given, they all feel that "a great injustice has been done our guinea-pig family."

We fear, however, that Dr. Hughes may have omitted some important steps in the obtaining of the specimen. While he admits that the guinea-pig faced west when the blood was taken, he does not state whether or not the operation was performed in a subdued light, which, it seems, is one of the requirements. Neither does he mention whether or not it was a red-headed guinea-pig; people with red hair, according to Dr. Abrams, are in a class by themselves. But most important of all, nothing seems to have been said by Dr. Hughes of the religious affiliations of the guinea-pig. As has been mentioned before, Abrams claims that one's electronic reactions vary with his religious belief so that Abrams can determine a man's religion by testing a specimen of his blood.[1] We reproduce with this article part of a page from Abrams' house-organ, *Physico-Clinical Medicine*, showing the various areas of dulness in a Catholic, a Methodist, a Seventh Day Adventist, a Theosophist, a Protestant and a Jew, respectively.

Who knows but Mr. Eisiminger may have assumed that the blood specimen he had under examination was from a Theosophist when the guinea-pig may have been a Christian Scientist? Now the area of dulness for Christian Scientists has not yet been mapped out by Albert Abrams—possibly it is the *terra incognita* of the abdomen. In any case, it was expecting too much of Osteopath Eisiminger to suppose that he would be able to give a correct diagnosis when such vitally important data as the religion of the patient was withheld.



Photographic reproduction from Albert Abrams' house organ *Physico-Clinical Medicine* for September, 1922. This chart represents the areas of dulness Abrams claims to have found in determining the religion of individuals by means of the "Electronic Reactions." 1 represents the areas of dulness for a Catholic; 2, Methodist; 3, Seventh Day Adventist; 4, Theosophist; 5, Protestant; 6, Jew.



This is the apparatus used by Albert Abrams and his disciples for diagnosing the disease of John Doe from a few drops of John's blood. The specimen of blood is put in the "dynamizer" (*"Dynam."*). The "energy" which is said to emanate from this blood ("energy" which nobody but Dr. Abrams and his disciples has ever been able to demonstrate) travels through the wire to the "rheostat dynamizer" (*"Rh. D."*), which is said to be used "for stepping up energy." The mysterious force is then said to travel by wire to the "vibratory rate rheostat" (*"Vib. Rheostat"*), which is said to admit energy "at vibratory rate of disease." From this the "energy" travels by wire to the "measuring rheostat" (*"Meas. Rh."*) for "determining energy." But it has not yet reached the end of its trip; it goes on through a wire to the electrode (*"E."*) which is applied to the healthy "subject" who has to face west and must be in a dim light! Then Abrams, and his followers, by percussing the abdomen of the "subject" purport to tell what ails John Doe and where his ailment is located.

Dr. Moorman tells us that he sent Osteopath Eisiminger "some sheep's blood on blotting paper furnished by him, with a blank, supposedly for a fifteen year old boy." "The next day," says Dr. Moorman, "I received the following diagnosis, for which I paid $10.00":

> "Congenital diminished resistance cerebro-spinal strain 38 ohms. Metastatic carcinoma of left lung and pancreas, 8 ohms. Neisserian infection genito-urinary tract, eyes, 4 ohms. Tuberculosis of genito-urinary tract, 4 ohms."

Dr. Moorman states that Eisiminger explains the phrase "congenital diminished resistance cerebro-spinal strain" as referring to hereditary syphilis. He says further that when Eisiminger delivered the diagnosis "he insisted on discussing the question of treatment and figured the cost at $290.00, but agreed to guarantee a cure for $250.00."

It is unfortunate, in the interest of scientific accuracy, that Dr. Moorman gives us no data regarding the religion of the sheep nor does he say whether or not it was a red-headed

1. A twelve-page reprint on the Abrams' vagaries will be sent on receipt of a two-cent stamp to cover postage.

animal. Neither does he mention whether the sheep was facing west and in a subdued light at the time that the blood specimen was taken. We mention all these details because they seem to be necessary to a proper understanding of the subject.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

HAYES ASTHMA CURE

To the Editor:—What do you know regarding the P. H. Hayes Asthma Treatment of Buffalo, N. Y.? LEE W. PAUL, M.D., Ilwaco, Wash.

ANSWER.—The Hayes asthma remedies, exploited by P. Harold Hayes, Buffalo, N. Y., were analyzed in the pharmaceutical institute of the University of Berlin by J. Kochs, and, according to the *Arbeiten aus dem Pharmazeutischen Institut der Universität*, Berlin, vol. iv, p. 122, with the following results. Six of the seven remedies were examined:

No. 781.—A cough medicine for use in colds, catarrhs, bronchitis and for the relief of asthma. Dose 20 to 30 drops. This was said by the analyst to contain about 6.5 per cent. of oils, consisting chiefly of oils of turpentine and peppermint, emulsified and sweetened with syrup.

T. I. Q.—A remedy that is to be taken in doses of 15 minims three times a day before meals. According to the report, it contained 13.7 per cent. of iodin in the form of potassium iodid, to which had been added a little wine and a small percentage (0.1) of hydrochloric acid.

No. 769 A-C.—A remedy to be given in doses of 30 minims at bedtime, to be repeated two or three times in several hours. This, says Kochs, was a slightly reddish syrup containing 6.7 per cent. of iodin combined as potassium, sodium and ammonium iodids.

T. II. Q.—A preparation to be taken in doses of 15 minims three times a day immediately after meals. The analytical report shows it to contain 1.08 per cent. of iron in the form of an iron peptonate.

No. 808.—These were small capsules filled with 0.1 gm. (1.5 grs.) of a loose white powder. It is said "to strengthen the lungs and reduce the tendency to taking cold." Analysis showed it to consist of quinin sulphate.

No. 763.—Small white sugar-coated pills. These are said to act mildly on the liver and regulate the digestion. The active principle of these pills as shown by the analysis was resin of jalap.

This information appears in "Nostrums and Quackery," Vol. I, and also in the pamphlet "Miscellaneous Nostrums" (price, 30 cents) issued by the Propaganda department.

BLASTOMYCETIC DERMATITIS—CYSTICERCUS CELLULOSAE CUTIS

To the Editor:—1. Where can I get any literature on blastomycetic dermatitis? What is the best local application for this? I know the regular treatment with iodids, the roentgen ray, curettement, arsphenamin, etc., but these do no good. Possibly there is some soothing application that can be made. 2. What is the best method of getting rid of *Cysticercus cellulosae*? I have no electrical outfit to try cataphoresis. I have Stelwagon, and other works. If you can suggest anything or any literature, I will be thankful. Please do not sign my name. INQUIRER, Alabama.

ANSWER.—1. An adequate account of blastomycetic dermatitis appears in most of the well known books on dermatology. Roentgen rays or curettement, with the iodids or arsphenamin, will usually cure the cutaneous lesions, and they benefit all of the lesions. If improvement is not secured from these measures, there may be an error in diagnosis. The treatment outlined in Stelwagon's book is brief, but it is correct and practical.

2. The treatment for infestation with *Cysticercus cellulosae-cutis* is surgical removal.

CONVERSION OF CENTIGRADE TO FAHRENHEIT

To the Editor:—1. Please give the easiest rule for converting a temperature in Centigrade into Fahrenheit. 2. Also a weight from kilograms into pounds. F. V. GAMMAGE, M.D., Akron, Ohio.

ANSWER.—1. Multiply by 9, divide by 5 and add 32.

2. Multiply by 2.2.

Medical Education, Registration and Hospital Service

COMING EXAMINATIONS

ALABAMA: Montgomery, Jan. 9. Chairman, Dr. Samuel W. Welch, Montgomery.

ARIZONA: Phoenix, Jan. 2. Sec., Dr. Ancil Martin, 207 Goodrich Bldg., Phoenix.

COLORADO: Denver, Jan. 2. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.

DISTRICT OF COLUMBIA: Washington, Jan. 9. Sec., Dr. Edgar P. Copeland, Stoneleigh Court, Washington.

HAWAII: Honolulu, Jan. 8. Sec., Dr. G. C. Milnor, 401 Beretania St., Honolulu.

ILLINOIS: Chicago, Jan. 9-11. Supt. of Registration, Mr. V. C. Michels, Springfield.

INDIANA: Indianapolis, Jan. 9. Sec., Dr. W. T. Gott, Crawfordsville.

KANSAS: Topeka, Feb. 13. Sec., Dr. Albert S. Ross, Sabetha.

MINNESOTA: Minneapolis, Jan. 2-4. Sec., Dr. Thomas S. McDavitt, 539 Lowry Bldg., St. Paul.

NATIONAL BOARD OF MEDICAL EXAMINERS: Written examination in Class A medical schools. Part I and II, February 12-14 and February 15-16. Sec., Dr. John S. Rodman, 1310 Medical Arts Bldg., Philadelphia. Application for the February examination must be sent in by January 1.

NEW MEXICO: Santa Fe, Jan. 8-9. Sec., Dr. R. E. McBride, Las Cruces.

NORTH DAKOTA: Grand Forks, Jan. 1. Sec., Dr. G. M. Williamson, 860 Belmont Ave., Grand Forks.

OKLAHOMA: Oklahoma City, Jan. 9-10. Sec., Dr. J. M. Byrum, Shawnee.

PENNSYLVANIA: Philadelphia, Jan. 30-Feb. 3. Sec., Mr. C. D. Koch, Professional Credentials Bureau, 422 Perry Bldg., Philadelphia.

RHODE ISLAND: Providence, Jan. 4-5. Sec., Dr. Byron U. Richards, State House, Providence.

SOUTH DAKOTA: Pierre, Jan. 16. Director, Dr. H. R. Kenaston, Bonesteel.

VERMONT: Burlington, Feb. 13. Sec., Dr. W. Scott Nay, Underhill.

WEST VIRGINIA: Charleston, Jan. 9. State Health Commissioner, Dr. W. S. Henshaw, Charleston.

WISCONSIN: Madison, Jan. 9-11. Sec., Dr. John M. Dodd, 220 E. Second St., Ashland.

Michigan October Examination

Dr. Beverly D. Harison, secretary, Michigan State Board of Registration in Medicine, reports the written examination held at Lansing, Oct. 10-12, 1922. The examination covered 14 subjects and included 100 questions. An average of 75 per cent. was required to pass. Of the 8 candidates examined, 6 passed and 2 failed. The following colleges were represented:

College	Year Grad.	Per Cent.
PASSED		
Johns Hopkins University	(1916)	82.7
University of Toronto	(1914) 81.4, (1917)	78.8
University of Budapest	(1921)*	84
University of Berne	(1917)* 76.3, (1921)*	76.5
FAILED		
University of Athens	(1913)*	65.4
University of Naples	(1920)*	70.3

* Graduation not verified.

Ohio Reciprocity Meeting

Dr. H. M. Platter, secretary, Ohio State Medical Board reports that eighteen candidates were licensed by reciprocity at the meeting held Oct. 3, 1922. The following colleges were represented:

College	Licensed by Reciprocity	Year Grad.	Reciprocity with
Georgetown University		(1921)	Dist. Colum.
George Washington University		(1921)	Dist. Colum.
Northwestern University		(1918)	Illinois
Detroit College of Medicine and Surgery	(1920), (1921)		Michigan
University of Michigan Medical School	(1912), (1921, 2)		Michigan
St. Louis University School of Medicine	(1903), (1921)		Missouri
New York Homeo. Med. Coll. and Flower Hosp.		(1921)	New York
Syracuse University		(1894)	New York
Hahnemann Med. Coll. and Hosp. of Philadelphia		(1901)	Indiana
University of Pennsylvania		(1904)	Penna.
University of Pittsburgh		(1914)	Penna.
Meharry Medical College	(1915) Mississippi,	(1921)	Missouri
Medical College of Virginia		(1895)	W. Virginia

Nostrums.—"The Profession has sunk into the Craft of deceiving, and amusing and making Profit by new Medicins, or Preparations brought into Fashion, and highly Esteem'd, as long as the Mode of Crying them up shall last."—The Craft and Frauds of Physic Expos'd. By R. Pitt, M.D., London, 1703.

Book Notices

REPORT ON ENCEPHALITIS LETHARGICA. Being an account of further enquiries into the epidemiology and clinical features of the disease; including an analysis of over 1,250 reports on cases notified in England and Wales during 1919 and 1920, together with a comprehensive bibliography of the subject. By Allan C. Parsons, M.R.C.S., A Medical Officer of the Ministry of Health. With contributions by A. Salusbury Macnalty, M.D., A Medical Officer of the Ministry of Health, and J. R. Perdrau, M.B., Pathologist, Lambeth Infirmary. Reports on Public Health and Medical Subjects, No. 11. Boards. Price, 10 shillings net. Pp. 344. London: His Majesty's Stationery Office, 1922.

The reports of about 1,300 cases of epidemic (lethargic) encephalitis form the basis of this study. There is perhaps little that is altogether new in the volume, but, it seems, there is nothing thus far reported about this strange disease that has not been taken into account; the names of 1,200 authors and more than 1,500 articles contributed on this subject during 1917-1921 comprise the bibliography. As a result of the studies of von Weisner, Netter, MacIntosh and Marinesco, it is said that the main histologic picture of epidemic encephalitis can be clearly drawn. The lesion is definitely inflammatory. The changes consist of a cellular infiltration in the perivascular lymph sheaths and in certain areas of gray matter. There is no marked change in the meninges, although in three cases examined by Bassoe and Hassin, the pia was slightly congested, with perivascular infiltration with plasma cells and leukocytes. In the brain substance the changes are most conspicuous in the upper part of the pons and in the basal nuclei. In most cases the small or medium sized veins were most affected. The cellular exudate consists chiefly of large and small mononuclear lymphocytes, along with a certain number of the polyblasts of Maximow, and a few plasma cells. The infiltration in some cases was found by MacIntosh to be so dense, particularly in the basal nuclei and upper parts of the pons, as to form actual foci. Such foci have been noticed to occur at times in the roots of the cranial nerves. Severe and widespread changes in the nerve cells, which ranged from slight chromolysis to complete disappearance of the Nissl granules, atrophy of the protoplasm, and shrinkage, atrophy and final disappearance of the nucleus, were noted by De Fano and Ingleby, and others. De Fano found within and without the nerve cells "minute bodies" which consisted of a central, generally basophil particle, and of a delicate little stainable body, irregularly round or oval. Similar "minute bodies" have been traced within and without the cells infiltrating a salivary gland from an acute case of epidemic encephalitis. De Fano tentatively suggests that such findings may be due to the presence in the tissues of a living agent, the cause of the disease, on the analogue of the Negri bodies in rabies.

UNTERSUCHUNGEN ÜBER DEN SYPHILISERREGER. Von Dr. med. et phil. F. W. Oelze, Assistent an der Hautklinik der Universität Leipzig. Paper. Pp. 74, with 9 illustrations. Leipsic: Leopold Voss, 1922.

In the progress of his research on the morphology of *Spirochaeta pallida*, executed with the help of a stereoscopic microscope, Oelze observed that the spirochete is really spiral shaped, which can be proved by watching it rotate within the observation chamber. The spirals wind clockwise. The last winding, or the apex of the spirochete, is likely to oscillate to the right or to the left. If one end of the spirochete is fixed, its whole body is able to oscillate in either direction. Single parts of a spirochete stretched near its center may oscillate to the right or to the left, but simultaneously in only one direction. On the living spirochete, no flagella are to be observed, a detail important for the microscopic diagnosis of syphilis. In accord with Silberstein, the author states that the use of the live dark field is the most satisfactory method for the recognition of *Spirochaeta pallida*. In opposition to Silberstein, he finds that the light field and the dark field, in judging a normal Giemsa specimen, are of equal value to the experienced observer. The Giemsa stain does not permit in the colored dark field a reliable distinction between *Spirochaeta pallida* and *Spirochaeta refringens*. If the adjustment of the dark field is not very accurate, an apparent shortening of the spirochetes, especially of *Spirochaeta pallida*, is observed. The diagnosis in the living dark field specimen is the most reliable method. The reactions of *Spirochaeta pallida* toward the different methods of staining are discussed in detail, and the measuring of the spirochete as to the length of its axis and its true length is reported in tabular form. The measuring of the series of *Spirochaeta pallida* coming from primary and secondary syphilis, and of nonpathogenic spirochetes occurring in the mouth, did not lead to the development of any practical results. It is uncertain whether biologic differences between different strains of spirochetes show morphologic manifestations. So far as the locomotion of the spirochete is concerned, observation in a quiet medium and in specially constructed chambers furnishes interesting data. Among those that are relevant as to diagnosis are the rotary motions and the bending and stretching in fresh specimens, and the oscillations of each end. As to microscopic research work on the influence of therapy, it should be kept in mind that syphilis in the rabbit and the hare is not an absolutely reliable guide for the experimental study of human syphilis. One also has to distinguish between the disappearance of the spirochetes in superficial lesions after arsenic therapy and their resistance in deeper structures. A sterilization of the whole system cannot be deduced from disappearance of the spirochete from surface lesions. Photomicrographs illustrate the contentions of the author. A schematic drawing explains the difference between the true length of the spirochete and the length of the axis, and throws light on the peculiarities of its spirals.

LA MÉTHODE PSYCHANALYTIQUE. Par le Dr. Raymond de Saussure, avec une préface de M. le Professeur Sigmund Freud. Paper. Pp. 187. Lausanne, Switzerland: Librairie Payot & Cie, 1922.

To the physician who is seeking a simple and conservative account of the principles and technic of psychanalysis, with well chosen references to the literature, this book can be heartily recommended. The language is simple, and the points are well illustrated by the case history and a dream analysis from a patient who made a good recovery. The author disclaims all originality and professes to give nothing but an account of the views of Freud, and it is especially striking that he is at great pains to emphasize the conservatism of Freud, his recognition of the influence of instinctive trends other than those of sex in the determination of dreams and functional symptoms, and the presence of constitutional deficiencies in hysterical patients which psychanalysis cannot change. It is the failure to grasp these facts that has done much to bring discredit on the method.

THE PRINCIPLES OF PHYSICS AND BIOLOGY OF RADIATION THERAPY. By Dr. Bernhard Kroenig, Professor of Gynecology and Obstetrics, etc., University of Freiburg im Breisgau, and Dr. Walter Friedrich, Chief of Division of Radium Therapy, University of Freiburg im Breisgau. With an Appendix by Dr. Henry Schmitz, Professor of Gynecology and Head of Department, Loyola University School of Medicine, Chicago, Illinois. Cloth. Price, $8. Pp. 271, with 117 illustrations. New York: Rebman Company, 1922.

This translation is not only valuable as a source of information, but also interesting as a historical document, being a milestone in the development of roentgenotherapy. It is the outcome of collaboration between a clinician and a physicist, demonstrating in its achievements the difference between a product of mere empirism and the building up of a medical proposition along exact scientific lines. At first the physical principles of roentgenotherapy are elucidated, and the pertinent technical terms are defined. Then follows the presentation of the conceptions and methods concerning the intensity, hardness and dose of the rays. The necessity of exact measuring is emphasized, and the various appliances used for this purpose are discussed and compared. The importance of secondary irradiation is explained and, contingent to that, the question of the field or fields of entrance is dealt with. This is followed by the determination of the biologic principles guiding roentgenotherapy. The biologic action of the rays transmitted through various filters is taken up and thoroughly discussed in a numerical determination of the relation of the biologic action to the hardness of the rays. This is carried through in observations on the skin, on malignant tumors and on the human ovary. The question of intermittent dosage and massive treatment confined to one sitting is dwelt on and decided in favor of the former.

The influence of heat as an enhancing factor for the therapeutic action of rays is decided in the negative. Each chapter is closed with a summary. An appendix deals with experimental work concerning the efficacy of various types of modern roentgen-ray apparatus. It also contains the reports on research work into the influence of the focus distance and the size of the field of entrance on the efficiency quotient of the original dose of rays. The last chapter contains the reports on experimental work on isodoses of short radium capsules, conducted by the translator in the roentgenologic institute of the Freiburg university. The difficulty of translating technical German into good English was satisfactorily overcome by the translator.

Medicolegal

Not Duty to Pursue Patient and Advise Operation

(Haskell v. Hanson (Minn.), 188 N. W. R. 1007)

The Supreme Court of Minnesota, in affirming an order denying the defendant's motion for a new trial after a verdict had been directed in favor of the plaintiff for the amount of his bill, says that, in February, 1915, the index finger of the defendant's left hand was cut by a saw, and the plaintiff was employed to attend him. The plaintiff amputated the finger and dressed the stump, which healed but remained sensitive and caused the defendant more or less pain when he used his hand. The plaintiff advised a second operation to overcome the pain, and it was performed in July, 1915. The plaintiff dressed the stump but once, informing the defendant that he might thereafter dress it himself. It healed properly, but the pain continued. The defendant did not return for further treatment. The parties lived in the same town, met frequently on the streets, and from time to time the defendant informed the plaintiff that his finger still pained him. In 1920, the defendant having failed to pay the plaintiff's bill, this action was begun to recover the amount thereof, resulting as stated above.

One of the grounds for the defendant's motion for a new trial was newly discovered evidence, shown by affidavits stating that after the trial the defendant had a third operation performed on his finger and as a result the pain disappeared. But whether the defendant had produced sufficient evidence to entitle him to go to the jury with the counterclaim which he had previously made for damages for alleged malpractice was the sole question presented to the supreme court. He contended that proper practice required the plaintiff to operate a third time to removed the portion of the finger which was the seat of the pain, and, because he neither operated nor advised having another operation, he was derelict in the performance of the professional duty he owed him. The plaintiff contended, on the other hand, that after he dressed the finger the last time the defendant neither asked for nor demanded further treatment, and that it was not his duty to volunteer his services.

The medical testimony offered by the defendant tended to show that the sensitive condition was caused either by the end of a nerve or by a bony projection in the stump of the finger, that the trouble could probably be remedied by an amputation higher up, and that, if a patient came to a physician and asked him what he should do, the physician, in the exercise of his judgment, might properly advise such an operation. None of the physicians testified that the plaintiff had failed to operate skilfully or that the sensitiveness resulted from improper medical or surgical treatment. They agreed that abnormal sensitiveness in the stump of an amputated member is not unusual, and that another amputation will not certainly remedy the condition.

Viewing the evidence in the light most favorable to the defendant, the court discovers nothing showing that the plaintiff failed to exercise due skill and diligence in anything done or omitted. True, his employment was general, and not special, and hence it was his duty to give his patient continued attention if his condition required it. He did not insure the removal of the abnormal sensitiveness in the finger when he performed the second operation. Although it was performed with reasonable skill, the result hoped for was not accomplished. The result of a third operation might have been more fortunate, but it was not the duty of the plaintiff to pursue the defendant and advise that it be performed. If the defendant wanted advice or further treatment, he should have gone back and asked for it. It is unreasonable to suppose that he would wait for five years in the continued expectation that the plaintiff would give him further attention. The supreme court is of the opinion that he failed to make a prima facie case of malpractice, and that the ruling of the trial court in directing a verdict for the amount of the plaintiff's bill, after the defendant's evidence was in, and denying the defendant's motion for a new trial, was correct.

Not Patent or Proprietary Medicine

(McHenry v. Royal Neighbors of America (Mo.), 242 S. W. R. 147)

The Kansas City (Mo.) Court of Appeals, in affirming a judgment in favor of the plaintiff on a fraternal beneficiary certificate issued by the defendant on the life of the plaintiff's wife, says that, when the latter applied for the insurance, she answered "No" to the question: "Have you within the last three years used any 'patent' or proprietary medicine?" The defendant contended that, as a violation of the warranty involved in this answer, the applicant had used pills, or tablets, of some description. The testimony tended to show that she had, at times, purchased tablets, or pills, for her own or her family's use in regulating the bowels or liver. There was no testimony showing that she actually took any of these medicines. Admitting that she did, were these "patent" or proprietary medicines? The physician who sold them testified that they were merely regulatory potions, which he had prepared for use in his practice. Webster defines "patent" as a writing securing to an inventor for a term of years the exclusive right to his invention, while "proprietary" is defined as "belonging or pertaining to a proprietor; considered as property owned; as proprietary medicine"; also, "proprietary articles, manufactured articles which some persons have an exclusive right to make and sell."

The physician who sold these pills or tablets to the insured testified that he did so without having prescribed them, and that he had prepared them for use in his practice, and made no claim that they were in any sense "patent" or proprietary. In the face of this evidence, the court holds that the medicine so purchased was neither "patent" nor proprietary.

Waiver of Privilege by Plaintiffs

(Hethier v. Johns (N. Y.), 135 N. E. R. 603)

The Court of Appeals of New York, in reversing a judgment obtained by the plaintiff that was affirmed by the appellate division of the Supreme Court of New York, says that the plaintiff, in this action to recover damages for personal injuries, gave evidence as to her physical condition after the accident which she charged was caused by the negligence of the defendant. She stated that, because of that condition, she consulted a physician, and described, in part at least, what occurred at the consultation. The physician was called as a witness by the defendant, who sought to examine him on the subject. His evidence was excluded. The ruling of the trial judge was erroneous. When the plaintiff in an action brought to recover damages for personal injuries caused by the negligence of the defendant describes these injuries and their results, and it appears that he has consulted, or been treated by, a physician in regard to them, he waives the protection of Section 834 of the New York Code of Civil Procedure (now Section 352 of the Civil Practice Act). The physician may then be called by the defendant and examined as to any information acquired by him in the course of such consultation or treatment. The rule as it was formerly understood was altered by the decision of this court in *Capron* v. *Douglass*, 193 N. Y. 11, 85 N. E. 827. This court took the position that, when the patient tenders to the jury the issue as to his physical condition, it must in fairness and justice be held that he has waived the obligation of secrecy which would otherwise exist.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Hygiene, Baltimore

November, 1922, **2**, No. 6

*Two Strains of Diphtheria Bacillus. P. D. Meader, Baltimore.—p. 601.
*Biochemical Differentiation of Bacteria. H. W. Smith, Indianapolis.—p. 607.
*Effect of Following Injection of Diphtheria Antitoxin on Intracutaneous Test for Virulence of Diphtheria Bacilli. M. Beattie, San Francisco.—p. 656.
*Relation Between Breast and Artificial Feeding and Infant Mortality. R. M. Woodbury.—p. 668.

Biochemical Differentiation of Bacteria.—A review is made by Smith of the more important literature on bactericidal substances, supplemented by a few experiments designed to substantiate the deductions which are drawn during the course of the review. Smith states that bacteria may be divided into two great groups, corresponding roughly to their reaction to Gram's stain.

Administering Diphtheria Antitoxin After Intracutaneous Test.—Since the intracutaneous lesion produced by as small an amount of diphtheria toxin as one-twentieth minimum lethal dose is not inhibited by the administration of an intraperitoneal injection of 200 units of antitoxin five hours after the injection of the toxin, Beattie asserts, it follows that a protective dose of antitoxin can be administered not only after intracutaneous virulence tests with pure cultures of morphologic diphtheria bacilli, as suggested by Eagleton and Baxter, but also can be administered after intracutaneous virulence tests with field cultures. This is possible because practically all virulent field cultures contain enough diphtheria bacilli to produce at least one-twentieth minimum lethal dose of toxin, when inoculated intracutaneously according to the technic described by Force and Beattie.

Infant Feeding and Infant Mortality.—The analysis of the influence of feeding on mortality made by Woodbury is based on data for 22,422 live born infants in eight cities. The analysis shows that artificial feeding, as actually practiced in typical city populations, is associated with a mortality between three and four times as high as the mortality among breast-fed infants. This excess mortality is not to be explained either by the slight overweighting of the group of artificially fed with infants in certain groups characterized by high mortality rates; and it appears in all nationality and in all earnings groups, though with variations depending probably on the particular conditions prevailing in the groups. The ratio is much higher (6.3) in the group with earnings of $1,250 and over (4.1).

American Journal of Medical Sciences, Philadelphia

November, 1922, **164**, No. 5

Endocrinology as Key to Solution of Major Medical Problems. C. E. de M. Sajous.—p. 625.
Résumé of Our Knowledge of Functions and Interrelations of Endocrine Glands. F. A. Faught and T. J. Ryan, Philadelphia.—p. 646.
*Auricular Flutter; Report of Cases. J. H. Keating and J. Hajek, New York.—p. 656.
*Wassermann Test in Its Relation to Prenatal and Congenital Syphilis. R. A. Kilduffe, Pittsburgh.—p. 677.
*Two Instances of Defective Interventricular Septum of Heart. H. W. Carey, Troy, N. Y.—p. 684.
*Treatment of Hypertoxic Cases of Typhoid Fever by Transfusion with Recently Artificially Immunized Blood. L. Neuman, Washington, D. C.—p. 690.
Case of Congenital Absence of Spleen. S. McLean and H. R. Craig, New York.—p. 703.
Delay in Treatment of Cancer. C. E. Farr, New York.—p. 712.
Vibrating Sensation in Diseases of Nervous System. R. T. Williamson, Manchester, Eng.—p. 715.
Relationship Between Central and Peripheral Involvement of Cranial Nerves. E. Sachs, St. Louis.—p. 727.
*Orthostatic Albuminuria: Study of Unusual Case. W. B. Blanton, Richmond, Va.—p. 742.

Tachycardia, Flutter, Fibrillation Are Stages in Cardiac Insufficiency.—Clinical experience has convinced Keating and Hajek that paroxysmal tachycardia, flutter and fibrillation are stages of the same pathologic condition causing cardiac insufficiency. Paroxysmal tachycardia is the first stage, flutter the second and fibrillation the third. Eight cases are reported. In all the cases the auricle showed a remarkable stability while fluttering. Atropin, rest, exercise or emotion, while affecting the ventricle, had no effect whatever on the auricular rate. Five of the cases were associated at one time or another with other forms of arrhythmia. As regards treatment, rest and digitalis restored many hearts to normal rhythm. The authors believe that the use of quinidin sulphate is still in the experimental stage. Some few patients are not influenced by treatment, and the condition persists for years.

Wassermann Test and Congenital Syphilis.—Kilduffe's investigations seem to warrant the conclusion that the results of cord Wassermanns are not to be unreservedly relied on when taken alone, and should not be made the sole basis for a diagnosis of syphilis. If the subject of prenatal and congenital syphilis is to be the object of a concentrated attack, it is obvious that serologic investigations must be extended to include not only both parents but also the child at birth, and in later infancy when the results of Wassermann reactions are apt to be more truly indicative of the presence or absence of syphilitic infection.

Defective Interventricular Septum.—The two cases described by Carey have to do with defects in the interventricular septum, and although both were congenital, one produced no symptoms whatever and the other caused symptoms, signs that were supposed to be due to an open ductus Botalli. In the interventricular septum in the first case, just beneath one leaflet of the aortic valve, was an aperture 1.5 cm. in diameter, which opened on the right side just beneath the adjacent leaflet of the pulmonary artery. On account of this defect there was an arteriovenous communication between the ventricles. In the second case there was a funnel-shaped depression in the muscle of the interventricular septum with an opening into the right ventricle at its upper margin.

Artificially Immunized Blood in Treatment of Hypertoxic Typhoid.—Two cases of typhoid fever of the hypertoxic type were treated by Neuman with recently artificially immunized blood, and the result in each case has been unusually gratifying. This is not intended as a general treatment for typhoid fever. The mild and moderately severe cases will respond to careful nursing and a high caloric diet. The rationale of this treatment is founded on experimental and clinical facts as they pertain to typhoid immunization.

Orthostatic Albuminuria.—Blanton cites a case of persistent albuminuria in a woman, aged 23. The history, physical examination and functional tests of the kidneys failed to show evidence of nephritis. Albumin persisted at the expiration of three weeks in bed, making it difficult at first glance to reconcile this case with the usual description of orthostatic albuminuria. However, the marked reduction of albuminuria (from 2 to 0.3 gm.) with rest and support of the back makes the condition clearly of the same general category as the postural or orthostatic albuminuria, though probably of a more severe grade than usually encountered. The evidence of a vasomotor disturbance in this patient is brought out, and this additional factor may account for the persistence of albuminuria with rest.

American Journal of Physiology, Baltimore

November, 1922, **62**, No. 3

Determination of Blood Catalase; Factors Affecting Ratio Between Quantity and Activity of This Enzyme. R. Okey, Iowa City.—p. 417.
*Studies in Fatigue. XII. Effect of Suprarenal Secretion on Nonfatigued and Fatigued Skeletal Muscle. C. M. Gruber, St. Louis.—p. 438.
Output of Sugar from Liver as Affected by Carbohydrate and Minimal Epinephrin. C. D. Snyder, L. E. Martin and M. Levin, Baltimore.—p. 442.
*Effect of Intravenous Sodium Bicarbonate on Intestinal Movements. C. E. King and J. G. Church, Nashville, Tenn.—p. 459.
Comparative Studies of Digestion. I. Digestive Enzymes of Coelenterates. M. Bodansky and W. C. Rose, Galveston, Tex.—p. 473.
Comparative Studies of Digestion. II. Digestion in Elasmobranchs and Teleosts. M. Bodansky and W. C. Rose, Galveston, Tex.—p. 482.
*Influence of Epinephrin on Metabolism in Various Excised Tissues. E. G. Martin and R. B. Armistead, San Francisco.—p. 488.
Study of Action Currents of Nerve with Cathode Ray Oscillograph. H. S. Gasser and J. Erlanger, St. Louis.—p. 496.
*Effect of Splenectomy on Integration of Muscular Movements in Rat. D. I. Macht and E. M. Finesilver, Baltimore.—p. 525.
II. Influence of Sodium Citrate on Peristalsis. W. Salant, N. Kleitman and L. H. Wright, Augusta, Ga.—p. 531.

*Utilization of Oxygen in Blood at Different Stages of Anoxemia. C. H. Greene and C. W. Greene, Columbia, Mo.—p. 542.
Reproduction on "Synthetic" Diets When Purified Agar is Added to Mixture. H. S. Mitchell, Battle Creek, Mich.—p. 557.
*Effects of Insulin on Experimental Hyperglycemia in Rabbits. F. G. Banting, C. H. Best, J. B. Collip, J. J. R. Macleod and E. C. Noble, Toronto, Can.—p. 559.

Effect of Suprarenal Secretion on Muscle.—Gruber found that suprarenal secretion evoked by splanchnic stimulation increases the height of muscular contraction of both nonfatigued and fatigued skeletal muscle. The quantity of epinephrin secreted must be fairly large judging from the height of betterment and the duration of improvement when compared with the results from injections of epinephrin intravenously. In as much as epinephrin secreted by splanchnic stimulation affects nonfatigued and fatigued skeletal muscles alike, it cannot be regarded a specific antagonist to the so-called fatigue substances. It increases the height of contraction and irritability of both muscles. Its exact mode of action has not been determined.

Effect of Sodium Bicarbonate Injected Intravenously on Intestinal Movements.—The intravenous injection of 50 c.c. of 2.5 and 6 per cent. sodium bicarbonate solutions into dogs called forth a vigorous motor reaction of the small intestine. The most constant feature of the reaction was an increase in tonus. Frequently local rhythmical movements appear, occasionally true peristalsis. The intensity of the reaction ran somewhat parallel to the dosage. The reactivity of the intestine was diminished after several successive administrations. The reaction in some cases was diminished by atropin, in others not. Epinephrin temporarily abolished it. The point of attack appeared to be peripheral in the enteric nervous mechanism. The possibility of harm, in the intravenous use of bicarbonate clinically, is pointed out.

Influence of Epinephrin on Tissue Metabolism.—Experiments by Martin and Armitstead are interpreted as showing that the thermogenic influence of epinephrin is not specific for any one kind of tissue but extends to most sorts, if not to all.

Effect of Splenectomy on Muscle.—The integration of the muscular movements and running speed were studied by Macht and Finesilver in rats by the so-called "rope method." The effect of splenectomy on such rats was investigated. It was found that the extirpation of the spleen did not interfere with the coordination of the muscles or the running time of the animals. On the contrary, the data obtained indicated that the muscular integration, if anything, was improved and the running speed was certainly shortened.

Influence of Sodium Citrate on Peristalsis.—Intravenous and intramuscular injections of sodium citrate stimulated the motor function of the intestines but its action on the small intestine was greater than on the large intestine, the amount required to stimulate the contractions being less, the latent period being shorter in the former than in the latter. The action of citrate also varied in different animals. Experiments with citrate on the isolated intestine indicated that stimulation was the main effect in the rabbit's intestine and depression the most frequent result in the cat's intestine. Citrate had no effect on the uterus in situ. Evidence was produced showing that stimulation of the intestine in intact animals by sodium citrate was due to its action on the endings of the motor nerve fibers and not on the muscle substance. It was suggested that the depression of the isolated intestine might be due to stimulation of the inhibitory mechanism.

Utilization of Oxygen in Blood in Anoxemia.—In the intact animal the Greenes have supported by new analytical and experimental data the following points: The utilization of oxygen from the blood is nearly constant, and is independent of the arterial oxygen tension until the venous oxygen reserve is exhausted. Thereafter, the oxygen utilization parallels the saturation of the arterial blood. Respiratory and circulatory crises occur at the approach of the point where the arterial saturation is reduced below the normal level of oxygen utilization. The oxygen tension of the alveolar air does not materially affect the blood flow until the crisis is approached. The blood flow and the oxygen utilization may show minor changes secondary to changes in the blood pressure or to the condition of the animal. In such changes the blood flow and the oxygen utilization vary inversely. The venous oxygen content represents an oxygen reserve available, apart from the circulatory compensations, for an increased oxygen consumption above the basal level.

Effect of Insulin on Experimental Hyperglycemia.—When the fall in blood sugar due to subcutaneous injection of insulin is thoroughly established, according to Banting et al., piqûre epinephrin, mechanical and carbon monoxid asphyxia and ether do not cause the usual degree of hyperglycemia. There may be a distinct increase in the percentage of blood sugar but very seldom is this sufficient to raise it to the normal level existing before insulin was given. Even when the insulin is given at the same time as the animal is subjected to the experimental condition used to cause hyperglycemia, the latter may be either entirely absent or greatly diminished.

Georgia Medical Association Journal, Atlanta

November, 1922, **11**, No. 11

Acute Conditions of Abdomen Requiring Surgical Interference. L. C. Fischer, Atlanta.—p. 427.
Surgery of Gastric Cancer. F. K. Boland, Atlanta.—p. 430.
What Clinical Manifestations Are Sufficient to Justify Diagnosis of Gallbladder Trouble? W. P. Nicolson, Atlanta.—p. 435.
Clinical Survey of Present Results Attained by Nonsurgical Drainage of Pathologic Gallbladders. G. M. Niles and H. N. Kraft, Atlanta.—p. 437.
Cholecystectomy Versus Cholecystostomy. T. C. Davison, Atlanta.—p. 441.
Maternal Mortality. C. A. Witmer, Waycross.—p. 445.
Apothesine. W. M. Folks, Waycross.—p. 447.
Spinal Anesthesia or Analgesia. B. H. Wagnon, Atlanta.—p. 449.
Operability. A. B. Patton, Athens.—p. 452.
Use of Pituitrin in Abdominal Surgery. J. C. Pate, Macon.—p. 454.
Double Uterus. H. W. Birdsong, Athens.—p. 455.
Improved Treatment for Recently Embedded Gunpowder Grains in Skin (Adhesive Plaster Dressing). M. B. Hutchins, Atlanta.—p. 458.

Iowa State Medical Society Journal, Des Moines

November, 1922, **12**, No. 11

Medical Ideals. E. S. Evans, Grinnell.—p. 427.
Acute Perichondritis of Larynx: Report of Case. F. A. Will, Des Moines.—p. 430.
*Thoracoscopy and Its Practical Importance, Especially in Surgery of Chest. H. C. Jacobaeus, Stockholm, Sweden.—p. 432.
Chronic Appendicitis. G. Kessel.—p. 437.
Diagnosis of Appendicitis. M. J. Kenefick, Algona.—p. 440.
Radiation Treatment of Hyperthyroidism and Basal Metabolism Test. H. Swanberg, Quincy, Ill.—p. 442.
Ophthalmology and Lesser Alcohols. J. M. Downing, Des Moines.—p. 446.
Indications for Urologic Examination. R. L. Latchen, Sioux City.—p. 449.
Adenoids and Eye Strain in School Children—Why Many Leave School. P. R. Wood, Waterloo.—p. 451.

Diagnostic Value of Thoracoscopy.—For the diagnosis and localization of pleural and lung tumors, Jacobaeus regards it as being of great importance to make a roentgen-ray examination before as well as after the induction of pneumothorax. By making a roentgen-ray examination after the induction of pneumothorax valuable information is obtained, which complete that already obtained by the roentgen-ray examination made before the induction of pneumothorax. By thoracoscopic examination valuable information is obtained for the diagnostic and localization of pleural and lung tumors, which successfully complete the result of roentgen-ray examination. If there is no opportunity of using a pressure differential apparatus, it might be advantageous to include pneumothorax previous to the operation in the pleural cavity. If pressure differential apparatus be employed, then pneumothorax for the thoracoscopic examination ought to be induced as shortly before the operation as possible, in order that the inflation of the lung after the operation may not be rendered more difficult or impossible. If the lung is inflated after the operation, more favorable conditions for the course of healing are eventually obtained.

Journal of General Physiology, Baltimore

November, 1922, **5**, No. 2

Stability of Bacterial Suspensions. IV. Combination of Antigen and Antibody at Different Hydrogen Ion Concentrations. P. H. De Kruif and J. H. Northrop, New York.—p. 127.
Stability of Bacterial Suspensions. V. Removal of Antibody from Sensitized Organisms. P. H. De Kruif and J. H. Northrop, New York.—p. 139.

Adhesiveness of Leukocytes to Solid Surfaces. W. O. Fenn, Boston.—p. 143.
Effect of Hydrogen Ion Concentration on Phagocytosis and Adhesiveness of Leukocytes. W. O. Fenn, Boston.—p. 169.
Influence of Ammonium Salts on Cell Reaction. M. H. Jacobs, Philadelphia.—p. 181.
Micro-injection Study on Permeability of Starfish Egg. R. Chambers, Woods Hole, Mass.—p. 189.
Relation of Reaction and of Salt Content of Medium on Nitrifying Bacteria. C. S. Meek and C. B. Lipman, Berkeley, Calif.—p. 195.
Equivalence of Age in Animals. S. Brody and A. C. Ragsdale, Columbia, Mo.—p. 205.
Permeability of Cells for Oxygen and Its Significance for Theory of Stimulation. E. N. Harvey, Woods Hole, Mass.—p. 215.
Permeability of Living Cells to Dyes as Affected by Hydrogen Ion Concentration. M. Irwin, Cambridge, Mass.—p. 223.
Aspects of Selective Absorption. W. J. V. Osterhout, Cambridge, Mass. —p. 225.
Sodium Chlorid and Selective Diffusion in Living Organisms. J. Loeb, New York.—p. 231.
Influence of Salts on Rate of Diffusion of Acid Through Collodion Membranes. J. Loeb, New York.—p. 255.
*Mechanism of Influence of Acids and Alkalies on Digestion of Proteins by Pepsin or Trypsin. J. H. Northrop, New York.—p. 263.

Influence of Acids and Alkalis on Digestion of Proteins.—The effect of the addition of acid on the amount of ionized protein has been compared by Northrop with the effect on the rate of digestion of gelatin, casein, and hemoglobin by pepsin. A similar comparison has been made of the addition of alkali in the case of trypsin with gelatin, casein, hemoglobin, globin and edestin. In general, it appears that the rate of digestion may be predicted from the amount of ionized protein as determined by the titration curve or conductivity. The rate of digestion is a minimum at the isoelectric point of the protein and a maximum at that p_H at which the protein is completely combined with acid or alkali to form a salt. The physical properties of the protein solution have little or no effect on the rate of digestion.

Journal of Laboratory and Clinical Medicine, St. Louis

November, 1922, **8**, No. 2

Technic of Basal Metabolic Rate Determination in Psychoneurotic Patients. B. S. Levine, Waukesha, Wis.—p. 73.
*Comparative Concentration of Urea in Blood and Saliva in Series of Pathologic Cases. H. W. Schmitz, New York.—p. 78.
Report of Seven Cases of Nicotin Poisoning. W. D. McNally, Chicago. —p. 83.
*Local Wassermann Test in Early Diagnosis of Primary Syphilis. D. Stern and H. Rypins, Minneapolis.—p. 86.
Action of Proteins and Blood Serum on Colloidal Gold Solution and Its Quantitative Interpretation. P. Reznikoff, New York.—p. 92.
*Central Influence of Atropin and Hyoscin on Heart Rate. W. J. R. Heinekamp, Chicago.—p. 104.
*Basal Metabolism and Blood Sugar Tolerance. G. H. Hoxie, Kansas City, Mo.—p. 112.
*Simple Method to Determine Coagulation Time of Blood. H. J. Goeckel, Cranford, N. J.—p. 122.
Mask for Alveolar Air Testing Outfit. H. J. Goeckel, Cranford, N. J. —p. 124.
Simple Apparatus for Continuous Extraction of Liquids by Liquids Lighter than Water. F. De Eds, San Francisco.—p. 125.
Modified Electrode for Use in Clinical Electrocardiography. H. M. Korns and E. J. Warnick, Cleveland.—p. 128.
Estimation of Uric Acid in Blood. H. Brown and G. W. Raiziss, Philadelphia.—p. 129.
*New Method for Sterilizing Proteins and Other Colloidal Compounds Without Denaturization. C. A. Mills, Cincinnati.—p. 134.
Method of Dividing Urinary Bladder for Experimental Purposes. J. A. H. Magoun, Jr., Rochester, Minn.—p. 136.
Modified Sahli Hemoglobinometer. W. K. Trimble, Kansas City, Mo. —p. 138.

Comparative Concentration of Urea in Blood and Saliva.—Comparative simultaneous analyses of forty-five specimens of blood and saliva, representing various pathologic conditions, are reported on by Schmitz. The urea content of saliva averaged 89.4 per cent. of that of the blood. It is asserted that salivary urea determinations may be employed in determining the functional activity of the kidneys where for any reason it is impracticable to obtain blood specimens.

Local Wassermann Test Diagnosis of Primary Syphilis.—The Wassermann test carried out by Stern and Rypins on the chancre serum of thirty-four demonstrated cases of primary chancre was positive in all cases. Of the thirty-four cases giving positive local Wassermann reactions, twenty showed negative blood reactions and no secondary manifestations. The local Wassermann reaction was positive with 0.0125 c.c. in all cases and in some cases with only 0.004 c.c. of chancre serum. Treatment of the lesions locally with a spirocheticide appears to have no effect on the complement fixing antibodies, although the spirochetes may disappear. A local as well as hematogenous site of origin for the specific complement-fixing antibodies appears established. In cases in which no dark-field microscope is available, in which the spirochetes are not found, or in which a lesion has been treated by a spirocheticide, the local Wassermann reaction is a practicable, simple and valuable means of diagnosis of primary syphilis at the time most important for prognosis and treatment.

Influence of Atropin and Scopolamin on Heart Rate.—The experimental evidence submitted by Heinekamp showed that small doses of atropin, 0.0003 gm. in dogs, 0.001 gm., in man, produce inhibition of the heart due to direct stimulation of the cardioinhibitory center. Scopolamin exerts a similar action to that of atropin on the medulla of *Pseudomys troosti* except that the primary stimulation is followed by depression.

Basal Metabolism and Blood Sugar Tolerance.—Experience leads Hoxie to believe that the simple closed circuit types of calorimeters are worth while in actual practice. The variations in reports on the basal metabolism rate seem due more to the condition of the patient than to the type of apparatus. Such reports, however, are not final. It is necessary to correlate clinical observation with the laboratory tests. The blood sugar tolerance test cannot be substituted for the calorimeter, nor any close parallelism drawn. Both studies are needed if a complete knowledge of the patient's function and vitality is sought. A revision of the terminology and standards of the blood sugar curves is needed before this study can be introduced into general practice.

Simple Method to Determine Coagulation Time of Blood.—Goeckel uses two hanging drop culture slides each with two ground out cavities. The cavities are of about 15 mm. diameter and approximately matched. The time of the appearance of the drop of blood after making the puncture is carefully noted and a rather liberal long drawn drop of blood is placed in each of the cavities of one slide by inverting the cavities over the puncture. This slide is then placed on top of the second slide. This gives enclosed chambers of small size, each with a drop of blood suspended on the upper wall of the chamber. When the slides are tilted on end the noncoagulated blood has a tendency to gather toward the bottom border giving a contrast of a light and a dark zone, which effect is accentuated by the slight magnification due to the curved surface of the cavity. This tilting is repeated about every thirty seconds after the third minute, alternating the incline to cause the blood to flow toward the lighter area. When the coagulation begins, a distinct clumping of the cells becomes visible. When the coagulation is completed no mobility will be seen, that is all parts of the drop will become fixed or coagulated. By this method a coagulation time up to seven minutes appears to be a safe limit.

Sterilizing Proteins Without Denaturization.—Mills asserts that protein solutions may be completely sterilized without alterations in their properties by letting stand the required length of time with the proper concentrating of mercuric chlorid, the precipitate being redissolved and the mercury rendered dialyzable by addition of sodium chlorid. The mercury and salt may then be removed by dialysis, placing copper outside the dialyzing tube to amalgamate with the mercury.

Laryngoscope, St. Louis

November, 1922, **32**, No. 11

Functional Examinations of Acuity of Hearing and Its Relation to Perception of Sounds of Different Pitches Produced by New Electric Acumeter. J. Guttman, New York.—p. 829.
Acute Mastoiditis, Complicated by Acute Concurrent Disease. C. F. Adams, Trenton, N. J.—p. 846.
Aural Lesions as Cause of Severe Systemic Infections. T. J. Harris, New York.—p. 850.
Hay-Fever. M. S. Ersner, Philadelphia.—p. 856.
Suction Treatment in Acute Infections of Ear. E. R. Carpenter, Dallas, Tex.—p. 864.
Peroral Endoscopy and Laryngeal Surgery. C. Jackson, Philadelphia. —p. 868.
Total Blindness of Both Eyes in Boy Seven Years of Age Cured by Ethmoid Operation, and Opening Sphenoid Sinus. D. N. Husik, Philadelphia.—p. 874.
Sensitization Diseases. A. A. Eggston, New York.—p. 877.
Reflexes from Respiratory Tract. H. C. Jackson, New York.—p. 887.
Self-Retaining Tongue-Depressor. A. J. Herzig, New York.—p. 900.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted below. Single case reports and trials of new drugs are usually omitted.

Irish Journal of Medical Science, Dublin

November, 1922, **5**, No. 9

Radical Cure of Inguinal Hernia. R. V. Slattery.—p. 389.
*Acute Leukemia with Cerebral Hemorrhage. T. T. O'Farrell.—p. 399.
Case of Faciohypoglossal Anastomosis for Facial Palsy. R. A. Stoney. —p. 404.
New Pelvimeter. R. E. Tottenham.—p. 409.

Acute Leukemia with Cerebral Hemorrhage.—The main symptoms in O'Farrell's case were vomiting with slight headache. Investigation into the girl's previous history revealed no outstanding feature, except that during the previous month she had had two rather severe uterine hemorrhages, each of about a week's duration. Her menstrual history prior to this had been quite normal. Then the temperature rose to 104 F. The only finding on examination was one enlarged and freely mobile gland in the left posterior triangle of the neck, just above the clavicle. No other enlarged glands could be felt. Then there developed rapidly, but in succession, sore throat and pains all over the body; the appearance of profound toxemia; a small subcutaneous hemorrhage on the front of the left shin; labored breathing, general distress and cyanosis and sweating commenced for the first time. The patient became delirious, passed her hand frequently over her head and tried to sit up in bed. At this time the heart presented a well marked tick-tack rhythm. Later the patient passed clots of blood per vaginam and then relapsed into a profound coma and death ensued soon afterward. The illness was of only one week's duration and the patient was aged just 16. Both lungs and pericardium were spotted over by many petechial hemorrhages. A small antemortem thrombus was found in the apex of the left ventricle. The glands at the roots of the lungs were not enlarged. The peritoneal cavity contained a moderate amount of rather blood stained fluid. There was a small petechial subserous hemorrhage in Douglas' pouch. The spleen was small and rather firm; a recent infarct was present. The stomach and intestines were normal and the mesenteric glands did not show any decided enlargement. The kidneys were somewhat enlarged and a little congested. On removing the calvarium and opening the dura, the cerebrospinal fluid did not appear to be under tension. The vessels on the surface of the brain were congested. During the removal of the brain a perforation occurred into what appeared to be a hemorrhagic cyst in the under surface of the left frontal lobe. The surface of the cerebellum was covered with subarachnoid petechial hemorrhages. On opening the left frontal lobe of the brain a large hemorrhage was found. In extent it was three inches from before backward, and two inches from above downward. It was situated obliquely in the anterolateral aspect of the lobe, limited in front by a thin shell of the left inferior frontal gyrus; was well walled off above by the marginal gyrus; below it had perforated onto the orbital surface; posteriorly it extended to the head of the caudate nucleus marginally and almost to the insula laterally. The hemorrhage lay altogether within the vascular area supplied by the cortical branches of the anterior cerebral artery. The blood clot, which was semifluid, contained what appeared to be ploughed up brain substance. Up to this point the clinical history taken with the general naked eye appearances would lead to a diagnosis of septicemia. Examination of the hematoxylin and eosin preparations revealed the fact that the white cells were not all polymorphonuclears; in fact, a very large number were mononucleated cells which resembled myelocytes, proving the case to be one of acute leukemia.

Lancet, London

Nov. 25, 1922, **2**, No. 5178

Minor Surgery of Children. L. E. Barrington-Ward.—p. 1101.
*Histogenesis of Myeloid Sarcoma. M. J. Stewart.—p. 1106.
*Intracranial Hemorrhage in New-Born; Fracture of Skull of Infant. A. C. Ballance and C. A. Ballance.—p. 1109.
Use of Dimol (Dimethylmonomethoxyphenol) in Treatment of Summer Diarrhea in Infants. A. N. M. Davidson.—p. 1112.
Treatment of Nonmalignant Affections of Colon. W. A. Lane.—p. 1114.
Preliminary Treatment of Acute Obstruction from Cancer of Colon by Cecostomy. J. P. Lockhart-Mummery.—p. 1117.
*Recuperative Ultraviolet Ray Baths. E. J. Deck.—p. 1117.

Histogenesis of Myeloid Sarcoma.—The view is advanced by Stewart that the osteoclast should be regarded as a true bone cell, arising from the fibrous reticulum or supporting fibrous tissue framework of the bone, periosteum, or endosteum as the case may be, rather than the reticulum of the marrow. That is to say, reticulum which is in process of forming osteoclasts should be regarded as already differentiated, to a considerable extent, as bone reticulum, while the osteoclast itself, although not osteogenic, is a specific bone cell, an end product cell with a definite and specialized function in relation to osseous tissue. In this view, myeloid sarcoma is a specific tumor of the fibrous framework of the bone in which the formation of fully developed osteoclast-like giant cells is continually going on. The difference between these "myeloid" giant cells and normal osteoclasts, increased size, increased number of nuclei, etc., are merely such as are commonly associated with conditions of neoplasia. Since none of its constituent cells are derived from specific bone marrow cells Stewart insists that the name "myeloma" is inaccurate and should be dropped. It has the further disadvantage that its use may cause confusion with the entirely different disease, multiple myeloma. Osteoclast sarcoma would be the obvious title. The use of the term "giant cell sarcoma" or "giant cell tumor," so much in favor with American writers is, in Stewart's opinion, to be deprecated, inasmuch as it fails to make a distinction between myeloid sarcoma on the one hand and frankly malignant giant cell sarcoma on the other. Chronic hemorrhagic osteomyelitis he believes to be a complete misnomer, being based on a quite erroneous view of the pathology of the condition. The myeloid tumor of tendon sheaths bears only a superficial resemblance to myeloid sarcoma of bone, and is probably endotheliomatous in nature.

Intracranial Hemorrhage in Newly Born.—A case of difficult forceps delivery is narrated by the Ballances in which the child sustained an intracranial hemorrhage because of a frontal bone fracture. An operation was performed on the fourteenth day. The broken fragment had allowed the escape of the effused blood from within the cranial cavity to the subpericranial region beneath the scalp. The depressed fragment of frontal bone was removed. The baby made a good recovery. Six weeks after the operation no opening in the skull could be detected, so rapidly had the pericranium thrown out new bone.

Ultraviolet Ray Baths.—Deck draws attention to the beneficial results to be obtained by exposing the whole body to multiple arcs giving forth rays in which the ultraviolet ray predominates. The method of producing this rich volume of rays is the electrical combustion of practically pure electrodes containing 99 per cent. of tungsten. It is asserted that this method of treatment may be beneficial in wasting diseases attended with anemia; as a rapid aid to healing for chronic ulcerations, such as bedsores and varicose ulcers. In the case of malignant disease there is no risk of aggravating the condition by the treatment or of doing the patient harm in any other way.

Annales de Médecine, Paris

November, 1922, **12**, No. 5

Early Occlusion in Ulcerous Colitis. P. Lecène and A. Lemierre. —p. 337.
*Superficial Phlebitis in the Tuberculous. L. Bernard et al.—p. 346.
*Familial Character of Schick's Reaction. E. Rist and Weiss.—p. 356.
Involuntary Movements in Epidemic Encephalitis. E. Krebs.—p. 374.
Digestive Assimilation. Legrand.—p. 402.
Case of Diatoma Hepaticum. P. Mauriac.—p. 415.

Superficial Phlebitis of Upper Limbs in the Tuberculous.—Bernard and his co-workers describe three cases of this rare affection. In one of them the tuberculous origin was directly established; in the other two cases it was very probable.

Familial Character of Schick's Reaction.—Rist and Weiss corroborate the findings of the Americans in this line.

Bulletin de l'Académie de Médecine, Paris

Nov. 7, 1922, **88**, No. 36

*Levulose in Diabetes. M. Labbé.—p. 189.
Increasing Frequency of Deaths from Cancer. Tuffier.—p. 193.
Intensive Serotherapy of Diphtheria. P. Lereboullet.—p. 201.
*Treatment of Tuberculous Peritonitis. P. F. Armand-Delille.—p. 203.
*Influence of Rays in Pathogenesis of Cancer. M. Benoit.—p. 206.

Levulose in Diabetes.—Labbé is rather skeptical about the supposed advantages of levulose in the treatment of diabetes. He does not believe that any carbohydrates are able to ameliorate the diabetic acidosis. It is rather the absence of fat and especially of proteins, which exerts a favorable influence. He believes, that carbohydrates relieve only the acidosis of healthy subjects deprived of carbohydrates.

Cure of Tuberculous Peritonitis by General Sun Baths.—Armand-Delille recommends the sun treatment, which may give results even where surgery has failed.

Influence of Rays in Pathogenesis of Cancer.—Benoit found that white light reduced the number of successful inoculations in mice sarcoma to 50 per cent.; ultraviolet light still more, while the red and infrared rays seemed to have a stimulating influence on the growth. His experiments were made on forty-eight mice and controls.

Bulletins de la Société Médicale des Hôpitaux, Paris

Oct. 27, 1922, **46**, No. 29

Treatment of Leprosy with Arsenical. Gougerot.—p. 1379.
Case of Chronic Epidemic Encephalitis with Hyperthermia. E. Ledoux. —p. 1382.
*Linked Liver and Renal Functions. G. Etienne and J. Bénech.—p. 1390.
Cell Count in Cerebrospinal Fluid. M. Renaud.—p. 1393.
*Shock Treatment of Puerperal Infection. M. Renaud.—p. 1394.
Radiography in Mutilating Leprosy. Delamare and Chukri.—p. 1396.
Epidemic Encephalomyelitis with Lumbosacral Localization. H. Bourges and M. Jobard.—p. 1399.
*Vaccine Therapy of Pulmonary Affections. Bourges and Jobard.—p. 1402.
*Polyneuritis Due to Tetrachlorethane. A. Léri and Breitel.—p. 1406.
Chronic Multiple Tendon Synovitis. P. Vallery-Radot et al.—p. 1412.

Connection of the Hepatic and Renal Functions.—Etienne and Benech show on three cases of edematous nephritis that the elimination of glycuronic acid follows closely the amount of urine excreted.

Shock Treatment of Puerperal Fever.—Renaud reports the almost immediate cure in a case of grave puerperal fever after intravenous injection of antistreptococcus serum plus epinephrin.

Vaccine Therapy of Acute and Chronic Pulmonary Affections.—Bourges and Jobard report favorably on the use of a mixed vaccine of staphylococcus, streptococcus and tetragenus in a case of asthma and another of pneumonia.

Polyneuritis Due to Tetrachlorethane.—Léri and Breitel describe two cases of polyneuritis of long duration due to tetrachlorethane. The predominating symptom was a paralysis of the interossei of the feet and hands.

Nov. 3, 1922, **46**, No. 30

*Subcutaneous Injections of Human Blood in Hemorrhages Following New Arsenical Preparations. J. A. Sicard.—p. 1419.
Two Cases of Cruveilhier-Baumgarten Cirrhosis (with Persistence of Umbilical Vein). J. Huber.—p. 1421.
Cure of Aplastic Hemorrhage by Repeated Subcutaneous Injections of Blood. P. Emile-Weil and V. Isch-Wall.—p. 1424.
Exfoliative Dermatitis After Intramuscular Injections of Bismuth. M. Pinard and Marassi.—p. 1434.
Anuria Due to Mercury in a Case of Chronic Nephritis. P. Menetrier et al.—p. 1435.
*Benzene Erythema. G. Milian.—p. 1441.
Meningococcus Sepsis with Permanent Nephritis. C. Gandy and L. Deguignand.—p. 1445.
*Excitation in Uremia Provoked by Calcium. P. Pagniez and A. Ravina. —p. 1451.
*Action of Calcium Chlorid in Normal Persons. A. Lemierre and J. Lévesque.—p. 1453.

Subcutaneous Injections of Human Blood in Hemorrhages Following New Arsenical Preparations.—Sicard employs subcutaneous injections of 100 to 200 c.c. of whole blood, preferably of a blood relative, in these cases, as well as in anemia. No addition of an anticoagulant is necessary if the blood is taken in a vessel the walls of which are coated with paraffin.

Benzene Erythema.—Milian describes a case of symmetric erythema of extremities in a man habitually working with dyes dissolved in benzene. Some tests showed that the epidermis of the patient was hypersensitive also to the application of cold. Milian believes that it was due to an alteration of sympathetic centers of the cord by syphilis.

Delirium in Uremia, Provoked by Calcium.—Pagniez and Ravina's patient was a nephritic having an azotemia of less than 0.1 per cent., with hypertension, albuminuria, permanent edema and constant gallop rhythm. He took 8 gm. of calcium chlorid. A state of violent excitation followed; with delirium and hallucinations, and the previously calm patient attempted suicide. They believe that it was due to a general effect of the comparatively large dose of a crystalloid, not to any special effect of the calcium chlorid.

Action of Calcium Chlorid in Normal Persons.—Lemierre and Lévesque examined the influence of a daily intake of 12 to 8 gm. of calcium chlorid on a healthy man on a salt-free diet. The subject lost in weight (loss of water), and felt extremely depressed physically and mentally on the last two days of the diet. Stopping the calcium chlorid, plus intake of sodium chlorid, produced a state of exhilaration and gain in water. For forty-eight hours he was what Ambard calls "salt drunk." The threshold of chlorid was lowered, while it did not change in a case of nephritis, in which the urecosecretory index was made worse. The tabulated details in comparative tests in health and in nephritis demonstrate anew the potent action of calcium chlorid on the interstitial circulation and the hydration of the organism.

Paris Médical

Oct. 21, 1922, **12**, No. 42

Psychiatry in 1922. A. Barbé.—p. 345.
Recent Works on Hallucinations. G. Halberstadt.—p. 352.
General Considerations on Psychanalysis. Schiltowski.—p. 357.
*Electric Accidents from House Current. V. Balthazard.—p. 361.
Mental Impairment from Extracortical Lesions. J. Camus.—p. 363.
Convulsions, Hysteria and Epilepsy. Chavigny.—p. 368.
Medical Responsibility. E. H. Perreau.—p. 370.

Electric Accidents from House Currents.—Balthazard adds another case to the list he has compiled since 1914 in which the ordinary alternating current of 110 volts electrocuted a person accidentally shortcircuiting this comparatively weak current. The action of the electric current is scarcely felt when the body opposes the normal resistance. It averages about 10,000 ohms, so the intensity of the current's action is only 110 volts divided by 10,000 ohms, which equals 11 milliamperes. But if the hands are wet or greased or if the feet are in water, the resistance of the body may drop to 1,000 ohms or less, and the quotient of 110 divided by 1,000 is 110 milliamperes and we know that 80 milliamperes of an alternating current will kill a dog.

Nov. 4, 1922, **12**, No. 44

Diseases of Children in 1922. Lereboullet and Schreiber.—p. 393.
*Sudden Death in Young Children. A. B. Marfan.—p. 409.
*Dyspepsia in Children. Taillens.—p. 413.
*Glycemia in Diphtheria. P. Lereboullet et al.—p. 417.
*Serotherapy of Scarlet Fever. R. Debré and J. Paraf.—p. 418.

Sudden Death in Children, Especially the So-Called Thymus Death.—Marfan believes, that there are many causes of sudden death in young children. Some sort of autointoxication in eczema may be the cause, while it is probably a local lesion of the superior cervical ganglion in cases of retropharyngeal abscess, etc. The only thing which these and other sudden deaths have in common is a certain predisposition of the young organism for it. Marfan describes a case of a rachitic girl of 21 months, who had suffered from several attacks of epileptiform convulsions before. The child was in a hospital under observation for a few days, and died suddenly, just while she was being dismissed as perfectly healthy. She had an enlarged thymus (35 gm.). The heart was in systole. The real thymus death is not due to compression of organs. It happens chiefly under anesthetics. The victims are usually pale and fat children, with rickets and enlargement of lymphatic glands. Marfan considers the causes of it as identical with the causes of rachitis, and recommends specific treatment if indicated by the Wassermann and tuberculin tests.

Dyspepsia in Children.—Taillens finds that dyspepsias in young children often have no anatomic causes. The usual

site is the stomach, and very many children have hyperchlorhydria, some have a hypochlorhydria. He rejects the typical test meal in favor of meals to which the children are accustomed.

Glycemia in Diphtheria.—Lereboullet and his co-workers found a normal sugar content in the blood of light cases, but a distinct diminution in severe diphtheria. This decrease was sometimes accompanied with signs of insufficiency of the suprarenal capsules, to which they attribute also the hypoglycemia.

Treatment of Scarlet Fever with Convalescents' Serum.—Debréand Paraf report favorably on the action of convalescents' serum in treatment of scarlet fever.

Schweizerische medizinische Wochenschrift, Basel

Nov. 9, 1922, **52**, No. 45

Anatomic Basis of Traumatic Tuberculosis. H. v. Meyenburg.—p. 1093.
Trauma and Tuberculosis of Lungs. R. Massini.—p. 1099.
Trauma and Bone and Joint Tuberculosis. F. Zollinger.—p. 1105. Conc'n No. 47.
Use of Corsci, Especially Maternity Corsets. Lévy-du-Pan.—p. 1109.

Nov. 16, 1922, **52**, No. 46

Bone and Joint Tuberculosis and Accident Insurance. Descoeudres.—p. 1117.
The Question of Traumatic Tuberculosis. M. Pierroz.—p. 1122.
*So-Called Traumatic Tuberculosis. D. Pometta.—p. 1124.
Trauma and Bone and Joint Tuberculosis. F. Zollinger.—p. 1126. Cont'n.

So-Called Traumatic Tuberculosis.—Pometta finds that most of the cases reported to the Swiss Accident Insurance Institute as a traumatic tuberculosis, are attributed to an event which cannot be considered as a trauma at all. It is usually simply part of the usual daily work or even only a movement. The causal connection of the tuberculosis with such a supposed accident becomes stronger and the accident more and more important in direct proportion to the time which elapses between it and the legal proceedings. Although this causal connection is usually more or less *bona fide* artificial, it is probable that the kind of work the patient was doing, is responsible for the localization and the development of the tuberculosis. But this is to be considered as an occupational trouble and not as an accident. Very often, the first changes supposed to be due to the accident, were already tuberculous.

Pediatria, Naples

Nov. 1, 1922, **30**, No. 21

*Attempts to Immunize Infants. A. Corica.—p. 985.
Child Mortality at Naples. A. de Capite.—p. 990.

The Opsonic Index in Infants Vaccinated Against Typhoid.—Corica injected antityphoid vaccine subcutaneously in six healthy infants and three healthy children between 8 and 11, and tabulates the findings with this experimental immunization. The opsonic index in the older children increased from 0.65 or 0.90 to 1.40 up to 2.07 after four injections. In the infants, the range before was from 0.76 to 0.97 and after five injections the range was only from 0.84 to 0.92; the index actually declined in three. When given by the vein, the opsonic index rose from 0.75 to 1.20 in the one infant tested, but in the older children the rise was considerable, by both routes, and there was a febrile reaction. In the infants the temperature did not rise above 38 or 38.5 C. The benefit from vaccine therapy, therefore, he says, must be from some nonspecific reaction.

Riforma Medica, Naples

Oct. 9, 1922, **38**, No. 41

Lymphocytosis and Lipolytic Power of the Serum in Pulmonary Tuberculosis. A de Martini.—p. 961.
Roentgen-Ray Treatment of Certain Eye Affections with Short Wave Rays. C. Guarini.—p. 963.
*Fuchsinophil Bodies in the Sputum. P. M. Franco.—p. 964.
*Risks of Spinal Anesthesia. M. Gioseffi.—p. 966.
Present Status of Erythremia. M. Reale.—p. 969.

Fuchsinophil Corpuscles in Sputum.—Franco found tubercle bacilli in 398 of 607 sputa examined, but fuchsinophil bodies were found only in 16.2 per cent. In the 103 with positive findings no tubercle bacilli could be found in 38. This group included 23 in which these fuchsinophil bodies were found for months or years before tubercle bacilli finally appeared in the sputum; in 15 cases the fuchsinophil bodies did not appear until after the tubercle bacilli had vanished from the sputum. He describes the characteristics of these bodies which range from the size of a gonococcus to that of the smallest erythroyctes. The Much granules are not so large and take stains differently. The physical-chemical reactions of the fuchsinophil bodies are like those of tubercle bacilli, although they do not bear formaldehyd so well as the latter. Franco emphasizes their importance for diagnosis and prognosis when tubercle bacilli cannot be found.

Risks of Intraspinal Anesthesia from Clinical and Medico-legal Standpoints.—Gioseffi cites statistics from the literature showing a mortality ranging from 0.07 to 0.5 per cent. of 3310, 9322, 3355, etc., in groups of cases in which the anesthetic had been injected intraspinally. Braun stated in 1921 that the hospital fatalities with it averaged 1 per cent. Gioseffi here reports a fatal case in detail. The otherwise healthy man of 65 was dismissed the twelfth day after a Bassini operation for left inguinal hernia. Soon afterward he complained of transient severe pain at the site of the intraspinal injection and in the legs. The fourteenth day, two days after leaving the hospital, symptoms of meningism developed with paresis, paraplegia and other symptoms of spinal cord disease, with dissociation of sensibility, septicemia, splenomegaly and jaundice, with death seven weeks after the first symptoms. Notwithstanding the fact that the symptoms did not develop until after a free interval of twelve days, Gioseffi accepts the causal connection with the intraspinal anesthesia, summarizing similar experiences from the literature.

Oct. 16, 1922, **38**, No. 42

*Intravenous Injections of Oxygen in Animals. L. Torraca.—p. 985.
Surgical Experiences with Oblique Inguinal Internal Hernia. L. Girolamo.—p. 986.
Myxoma of Ovary. R. Micotti.—p. 988.
Fight Against Venereal Diseases in Sweden. A. Sundqvist.—p. 991.
Present Status of Deforming Osteo-Arthritis. E. Aievoli.—p. 993.

Intravenous Injections of Oxygen in Animals.—Great quantities of oxygen introduced intravenously do not dissolve completely in the blood. Torraca finds that one part accumulates in the peritoneal, but not in the pleural or pericardial cavity. Some of the gas is eliminated through the skin, which can be plainly seen if the animal is submerged in water.

Anales de la Facultad de Medicina, Lima

May-June, 1922, **5**, No. 1

*History of Solanum Variegatum. Ache.—p. 42.
*Prophylaxis of Peruvian Verruga. J. Arce.—p. 58.
Aims and Purposes of Teaching of General Pathology. H. F. Delgado. —p. 82.
*Malta Fever in Lima. R. Rebagliati.—p. 94.

Medical History of the Cucumber in Peru.—Ache quotes from Peruvian poetry and novels to show the traditional reputation of the cucumber as the cause of dysentery and malaria. He has also found in the archives of the Lima Medical Society for 1862, reports of several cases of severe dilatation of the stomach, paralysis of bladder and bowel and peritonitis, all following two or three days after eating cucumbers. In one case the young man had eaten two exceptionally large ripe cucumbers when very tired and thirsty.

Prophylaxis of Peruvian Verruga.—Arce explains that the cause and mode of transmission of this disease in both its mild and its malignant form are now more than suspected. It seems to be peculiar to a certain small district in Peru, and hence it would certainly be possible to stamp it out. This would eradicate it and banish this disease from the face of the world. He pleads to have this work undertaken without delay, before the scourge has extended to other zones in or outside of Peru offering equally favorable conditions for the intermediate host.

Malta Fever in Lima.—Rebagliati describes some endemic foci of this disease in Peru. He insists that it should be called by a more descriptive name, such as melitococcia. The disease may run a course from a few days to a year or more. An autogenous vaccine has given the best results in treatment in his experience. The onset may be insidious or

stormy, with a chill, neuralgia, sore throat or orchitis. The diagnosis is rendered positive by the blood findings. Transmission may be by flies as well as by goat's milk.

Anales de la Facultad de Medicina, Montevideo

June-July, 1922, **7**, No. 4-5

*Radiosusceptibility. F. Voltz.—p. 187.
*Case of Banti's Disease. J. Nin y Silva.—p. 192.
*Deep Radiotherapy for Sarcoma. J. Nin y Silva.—p. 199.
Experiences with Delbet's Stock Vaccines. E. Blanco Acevedo.—p. 203.
Idem. Clivio Nario.—p. 211.
*Aneurysm in Neck. Manuel B. Nieto.—p. 215.
*Median Glossitis. José May.—p. 219.
Experiences with Intraspinal Anesthesia. G. J. Devincenzi.—p. 228.
Report of Foundling's Asylum. Maria Armand Ugón.—p. 238.
Extraction of Corncob in Rectum. V. Pérez Fontana.—p. 264.
Bismuth in Treatment of Syphilis. Luis M. Otero.—p. 267.

Recent Research on Sensitiveness to Radiant Energy.—Voltz relates that his own experimental research has demonstrated that the radiosensitivity of a cell is proportional to its kinetic energy, its energy in an unstable form. It also depends on its nourishment. External factors cooperate likewise: warmer temperatures, exposure to light, injurious influences of various kinds, all these increased the radiosensitivity of the plants in his experiments. The biologic effect of irradiation may thus differ entirely with differences in the nourishment, illumination, temperature or external noxious influences, although the rays and other circumstances may be the same in all.

Splenectomy in Banti's Disease.—Nin y Silva casually discovered the enlarged spleen, debility and asthenia of the first stage of Banti's disease in a woman of 55 with influenza. After splenectomy all the symptoms subsided; in eleven days the erythrocytes had increased from 3,100,000 to 4,656,000 and the hemoglobin from 40 to 75 per cent. The spleen weighed 4 kg. and showed the changes characteristic of the first phase of Banti's disease. The general condition improved at once and the patient gained several pounds in weight, but the headaches to which she had long been subject continued. The spleen had been enlarged for about a year.

Sarcoma of Leg Treated by Deep Roentgenization.—The sarcoma had developed on the dorsum of the foot of the young woman under a nevus. She refused amputation and the tumor was resected but in three months three metastatic tumors developed near the ankle and the glands in the inguinal region were swollen. Under deep roentgen crossfire exposures the lesions in the leg rapidly retrogressed and the general health improved. In two months she had gained nearly 6 kg. but three small tumors had appeared in the leg, one at the site of the old main tumor.

Ligation of Carotid Artery for Aneurysm.—In Nieto's case the aneurysm had developed in two weeks, but the symptoms had been only those of a phlegmon in the neck. The aneurysm was infected. The common carotid was ligated, and this cured the aneurysm without any cerebral disturbances at the time or during the two years since to date.

Median Glossitis.—The peculiar lozenge-shaped aspect of the chronic lesion in the middle of the tongue is shown in an illustration. The painless, stationary course, refractory to all treatment is emphasized.

Deutsche medizinische Wochenschrift, Berlin

Oct. 13, 1922, **48**, No. 41

Importance of Colloids for the Action of Drugs. H. Kionka.—p. 1371.
Comment on Kleinschmidt's "Eruptions in Syphilis." A. Buschke.—p. 1373.
Psychosexual Element in Asthma. N. Costa.—p. 1373.
*Indications for Calcium Chlorid. P. Bernhard.—p. 1375.
Pulmonary Changes in Puerperal Sepsis. J. Hagemann.—p. 1376.
Toxicity of Aromatic Nitro-Compounds. J. Stukowski.—p. 1377.
*Roentgen Cure of Jaundice. G. Szemző.—p. 1379.
Treatment of Hydrocele. F. Franke.—p. 1381.
Case of Idiopathic Cyst of the Common Bile Duct. H. Bolle.—p. 1381.
Tissue Necrosis from Scrap from Indelible Pencil. E. Glass.—p. 1383.
Verbal Suggestion in Hypnotism. F. Wolf.—p. 1383.
Inherited Syphilis and Twin Pregnancies. F. Thoenes.—p. 1386.
*Pedunculated Tuberculosis of Peritoneum. S. Semenow.—p. 1387.
Muscle Changes in Asiatic Cholera. Warasi.—p. 1387.
Sciatic Neuralgia Due to Formation of Calculus. C. X. Hiéroklès.—p. 1388.
Laparotomy to Extract Swallowed Pieces of Metal. Kern.—p. 1388.
Substitution of Potassium Iodid by Tincture of Iodin. A. Winckler.—p. 1388.
Bronchiectasia. Goldscheider.—p. 1389.
Bandages for the Eyes. K. Steindorff.—p. 1389.

Indications for Calcium Chlorid.—Bernhard corroborates the favorable influence of injections of 5 or 10 c.c. of a 10 per cent. solution of calcium chlorid in asthma. He also found that it had an excellent, although passing, effect in edema of lungs.

Roentgen Cure of Jaundice.—The icterus was chiefly dynamic. No bilirubin was present in the urine, no acholia in the feces. The icterus was cured by the application of one erythem dose of roentgen ray on the spleen.

Pedunculated Tuberculosis of Peritoneum.—The case was an ascitic form with formation of comparatively large pendulous nodules, like the perlsucht of cattle. It seems to be the fourth case on record.

Klinische Wochenschrift, Berlin

Oct. 21, 1922, **1**, No. 43

Biological Problems in Neurosyphilis. A. Hauptmann.—p. 2121.
*Spirochete Icterogenes and Pseudoicterogenes. P. Uhlenhuth and M. Zülzer.—p. 2124.
Experiments on Vitamins. F. Groebbels.—p. 2130.
Influence of Inorganic Salts on the Sugar Metabolism. I. St. Lorant.—p. 2131.
Behavior of Blood Platelets After Injections of Irritants. R. Stahl.—p. 2132.
Combination of Heat and Hofmeister's Anionic Series as Reaction of Liability of Plasma. G. v. Gerlóczy.—p. 2134.
*Roentgen Ray Acute Intoxication. E. Schlagintweit and H. Sielmann.—p. 2136.
Extirpation of Submaxillary Gland in Angina Ludovici. E. Rehn.—p. 2138.
Acromegaloidism. R. Ehrmann and L. Dinkin.—p. 2139.
Comment on Curschmann's Article in No. 32. O. Porges and D. Adlersberg.—p. 2139.
Vasoconstricting Substances in Blood. W. Hülse.—p. 2140.
Acid-Alkali Equilibrium in Experimental Kidney Changes. K. Beckmann.—p. 2140.
Teratomas of Larynx. H. Lichtenstein.—p. 2141.
Case of Malformation of Colon. W. Horn.—p. 2141.
Surgical Treatment of Epilepsy. L. Pussep.—p. 2142.
Hygienic Views on Present State of People's Nutrition. A. Juckenack.—p. 2145.
Importance of Roentgen Rays for Modern Natural Sciences. P. P. Ewald.—p. 2147.
Extrasystoles and the Predominance of Automatism of Subordinate Centers. C. J. Rothberger.—p. 2150. Cont'd.

Spirochete Icterogenes and Pseudoicterogenes.—Uhlenhuth and Zülzer state that saprophyte spirochetes of the water may be changed by cultivation in culture mediums containing serum until they behave serologically like *Spirochete icterogenes.* Though the transmission of Weil's disease by rats seems to be well established, a primary infection from the water is not impossible.

Acute Toxic Constitutional Reaction to Roentgen Exposures.—Schlagintweit and Sielmann found in cases of severe disturbances following large doses of roentgen rays a dilution of the blood manifested by a decrease in the relative amount of erythrocytes and a decrease in the chlorid content of the blood. Sodium chlorid given in whatever form gave full relief. The quickest way was to give 1 c.c. of a 5 per cent. solution intravenously, but the ingestion of 5 or 10 gm. by the mouth also had a favorable effect.

Münchener medizinische Wochenschrift, Munich

Oct. 13, 1922, **69**, No. 41

*Experiments on Colloid Treatment. H. Bechhold.—p. 1447.
Pathology of Tonsillitis. A. Dietrich.—p. 1449.
*Hematoidin. H. Fischer and F. Reindel.—p. 1451.
Treatment of Syphilis with Bismuth Compounds. G. Giemsa.—p. 1452.
*Quantitative Wassermann Reaction. B. Spiethoff.—p. 1453.
*Quantitative Modification of Abderhalden's Reaction. A. Gersbach.—p. 1454.
Diseases of Liver and Gallbladder. R. Ehrmann.—p. 1457.
Postoperative Tetany and Pregnancy. H. W. Stenvers.—p. 1458.
Local Eosinophilia in Postpneumonic Effusion. Schotter.—p. 1460.
Bleeding in Goiter Operations. A. Krecke.—p. 1461.

Experiments on Colloid Treatment.—Bechhold demonstrates the possibility of preventing the death of mice inoculated with the bacillus of swine plague, in doses that otherwise kill in two to four days. He accomplished this by the simultaneous or even subsequent injection of different substances. All the substances which protected in a marked manner were colloids, although not all of them were proteins.

Therefore Bechhold proposes the general term "colloid treatment" instead of the special term "protein treatment." Water had a favorable influence, which he attributes to its action on the corpuscles and proteins of the blood. Some of the proteins (for example an emulsion of killed staphylococci) and some of the substances leading to leukocytosis (croton oil) were without any influence. Colloidal metals did not protect more than their "protecting colloid," when used alone. Peptones were without appreciable influence. The dose is very important: It must not be too small nor too big. The optimal amount of casein by the vein was 0.0027 to 0.011 gm. per kg. of body weight. This would be in men of 70 kg., about 0.189 to 0.77 gm.

Hematoidin.—Fischer and Reindel find that hematoidin gives reactions and crystals which are identical with mesobilirubin, a reduction product of bilirubin. Its crystals in the brain, liver, etc., correspond to bilirubin.

Quantitative Wassermann Reaction and Changes in it During the Day.—Spiethoff demonstrates the value of serial complement fixation with different amounts of serum. He finds by this method that there can be changes in the titer during the day.

Quantitative Modification of Abderhalden's Reaction.—Gersbach uses the original method, and determines the dialyzed amino-acids with Riffart's method (using buffers).

Wiener klinische Wochenschrift, Vienna

Sept. 28, 1922, **35**, No. 38-39

Universal Skin Affections in Infants. C. Leiner.—p. 751.
*Pathology of Argyll Robertson Pupil. E. Redlich.—p. 756.
*Therapeutic Use of Skin Anaphylaxis. K. Stejskal.—p. 761.
Pains in the Stomach. E. Schütz.—p. 762.
Auto-Observation of Steinach Operation Without Rejuvenation. M. Zeisel.—p. 764.
*Is Ozone a Remedy? J. Pichler.—p. 765.
Scientific Bases of Public Health Work. F. Hamburger.—p. 768.
Importance of Procuring Human Milk for Infants' Welfare Work. A. Reuss.—p. 771.

Pathology of Argyll Robertson Pupil.—Redlich attributes the Argyll Robertson phenomena to a lesion of afferent fibers of the nucleus of the oculomotorius. The lesion is due to the metaluetic affection of the ependyma of the aqueduct of Sylvius, analogous to the meningitis.

Possibilities of Therapeutic Use of Skin Anaphylaxis.—Stejskal reports the favorable influence of injections of any protein into the neighborhood of inflamed or stiff joints or just below epitheliomas of the skin, although he does not consider this method of treatment sufficiently tested for general use.

Is Ozone a Remedy?—Pichler points out that pure ozone does not smell. The smelling substances produced by electric sparks are oxids of nitrogen, which are only noxious.

Oct. 5, 1922, **35**, No. 40

Tuberculosis and Pregnancy. H. Peham.—p. 781.
*Relations of Acid and Alkali to Tetany. H. Elias.—p. 784.
Malignant South American Lymphogranuloma of Mycotic Origin. W. Haberfeld.—p. 786.
Rubin's Test for Patency of Fallopian Tubes. J. Novak.—p. 789.
Comment on Sicher's "Genesis of Hunger Pain." O. Porges.—p. 791.
Statistics of Tuberculosis in Children. K. Barchetti.—p. 792.

Relations of Acid and Alkali to Tetany.—Elias points out that a therapeutic influence of acid or alkali does not prove anything for the etiology of any disease. This is especially true in tetany. In tetany, disturbances in the acid alkali metabolism are not essential. The phosphoric acid ion seems to have a special function in increasing the irritability of nerves in very small doses. Its amount in the blood is increased in tetany.

Oct. 12, 1922, **35**, No. 41

Treatment of Puerperal Fever. H. Peham.—p. 799.
Etiologic and Pathogenetic Classification of Epidemic Encephalitis. W. Berger.—p. 801.
Determination of Metabolism in Patients. Marie Krogh and O. Rasmussen.—p. 803.
Processes Present in Plants During the Latency of Injury by Roentgen Rays. E. Petry.—p. 806.
*Treatment of Sciatica by Injections. A. Bum.—p. 806.
Comment on Maliwas' "Mineral Springs." J. Schütz.—p. 808.

Treatment of Sciatica by Injections.—Bum injects quickly 120 to 150 c.c. of a solution containing 0.7 per cent. sodium chlorid and 0.07 to 0.1 per cent. of calcium chlorid into the perineurium of the sciatic nerve. He believes that the favorable action is purely mechanical, and rejects therefore all other substances which might be harmful.

Zentralblatt für innere Medizin, Leipzig

Sept. 30, 1922, **43**, No. 39

Impetigo-Nephritis. E. Hering.—p. 633.

Oct. 7, 1922, **43**, No. 40

*Specific Treatment and Protein Therapy. W. Vermehren.—p. 649.

Nov. 4, 1922, **43**, No. 44

Review of Laryngology (July-October, 1922). O. Seifert.—p. 713.
Conc'n No. 45, p. 729.

Specific Treatment and Protein Therapy.—Although admitting the nonspecific part in the action of vaccines, Vermehren emphasizes their advantages over the nonspecific injections of proteins.

Nederlandsch Tijdschrift v. Geneeskunde, Amsterdam

Oct. 21, 1922, **2**, No. 17

*Bacteriophagy of Typhoid Bacilli. J. W. Janzen and L. K. Wolff.—p. 1818.
*Umbilical Colic in Children. H. L. Coopman.—p. 1825.
The Duration of Dreams. G. Jelgersma.—p. 1828.
Some Reaction Phenomena Accompanying Physiologic Phenomena. J. J. van de Belt.—p. 1831.
Uterine Cancer with Survival for Ten Years. H. L. Coopman.—p. 1844.

Typhoid Bacteriophage.—Janzen and Wolff report some curious findings with bacteriophagy of different strains of typhoid bacilli. They tabulate them for comparison and comment on the pitfalls when we commence to generalize from special findings. Their experience warns of the necessity for beginning again at the beginning in each new research of the kind. Their experience has further increased their admiration of d'Herelle's pioneer work in opening this new field for research.

Umbilical Colic in Children.—Coopman relates a typical case out of his wide experience with such cases, which clears up the cause of recurring colic in the navel region in children; the child usually vomits during the colic. When there is no tender point on the right, close to the navel, and the pain is alike on both sides of the navel and the temperature keeps normal, a neurosis may be accepted as the explanation, although this form is rare. But when the recurring transient colic in the navel region is accompanied with the tender point to the right, it is a manifestation of chronic appendicitis, and can be permanently cured by appendicectomy.

Hygiea, Stockholm

Oct. 30, 1922, **84**, No. 20

*Technic for Pneumoperitoneum. D. E. Holmdahl.—p. 833.
Graphic Abbreviations for Lung Findings. C. O. Segerberg.—p. 846.

Improved Technic for Artificial Pneumoperitoneum.—Holmdahl extols the advantages of puncturing for pneumoperitoneum in the left anterior axillary line, the patient lying on his right side, the shoulders raised a little. The needle is introduced just above the margin of the thorax, just far enough down to escape the pleura, at about the eighth intercostal space. As the needle pierces the thorax wall and the diaphragm and emerges in the open abdominal cavity, the manometer gives warning at once by the negative pressure.

Upsala Läkareförenings Förhandlingar, Upsala

Sept. 11, 1922, **27**, No. 5-6

*Puerperal Thrombosis and Embolism. P. Häggström.—p. 305.
Cystinuria in Sweden. C. T. Mörner.—p. 351.
Tests for Cystin in Urine. C. T. Mörner.—p. 367.

Puerperal Thrombosis and Embolism.—Häggström found varices in 112 of the 11,476 maternity cases investigated, and ten of these 112 developed thrombosis. The lying still and the relaxed position after childbirth and the common bradycardia aid in the predisposition to thrombosis at this time, as also the generally increased numbers of blood platelets and of leukocytes. The latest views regard infection as of minor importance in thrombosis, although opinions are divided on this.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JULY-DECEMBER, 1922

The following journals have been abstracted in the Currrent Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where located.

Acta Chirurgica Scandinavica. Irregular. 20 kroner. Stockholm.
Acta Medica Scandinavica. Irregular. 20 kroner. Stockholm.
Acta Pediatrica. Irregular. $6 per volume. Upsala.
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SOCIETIES

A.—Association
Acad.—Academy
Am.—American
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical or Medicine
Nat.—National
Pharm.—Pharmaceutical or Pharmacy
Phys.—Physicians
Ry.—Railway or Railroad
S.—Society
Surg.—Surgical Surgeon or Surgery

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